

# **STATE TITLE V BLOCK GRANT NARRATIVE**

**STATE: TN**

**APPLICATION YEAR: 2005**

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and Certifications may be obtained from the Tennessee Department of Health, Maternal and Child Health Section, located at 425 5th Avenue, North, 5th Floor, Cordell Hull Building, Nashville, TN 37247.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Public review and input regarding the MCH Block Grant will continue a process started with year one of this cycle. Each Regional Health Council receives a copy of the Block Grant through the regional director for review and comment. Written comments will be reviewed and included with the next Block Grant submittal. MCH continued its history of holding public meetings in concert with the WIC program regarding its role and services offered at the county level. A letter and fact sheet about both programs were sent to over 500 agencies and health care providers, and all physician members of the Tennessee Medical Association and the Tennessee Hospital Association announcing the location and time of the public hearings. Three public hearings were held across the state in June 2004 in conjunction with the WIC program staff. All health users of the State's GroupWise system were sent an email; the information was released to the press; and the information was placed on the Department's web site. Any findings will be addressed.

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

While Tennessee has enjoyed some favorable economic trends, with a 4.8% non-seasonally adjusted unemployment rate statewide (as compared to 5.4% nationally), a diverse market economy, low state taxes, and no personal income tax which attract business and industry, this has been superimposed on a background of dwindling federal aid, loss of jobs and business revenue, and increasing local taxes. The State has been continually challenged with balancing its budget. Inner-city urban areas, small rural areas and unique areas such as those in the Appalachian Mountains have experienced increasing poverty.

Tennessee is a diverse state which covers 41,220 square miles of land area and is approximately 500 miles from east to west and 110 miles from north to south. The state is divided into 95 counties, each with a health department mandated by state law and located in the county seat. For departmental administrative purposes, the counties are grouped into seven rural and six metropolitan health regions.

Topographically, as well as culturally and economically, the state is divided into three grand regions. East Tennessee is a 35 county area, containing the Appalachian Mountains and bordered by Virginia, Kentucky, North Carolina, and Georgia. This region contains Knoxville and Chattanooga, the third and fourth largest cities, respectively. Johnson City, with a population over 50,000, is located in the extreme upper East End of the region and is the location of East Tennessee State University (ETSU) and the Quillen-Dishner School of Medicine. The ETSU Genetic Center provides on-going treatment and patient education after cases are confirmed by the Genetic Metabolic Centers. Erlanger Hospital in Chattanooga provides similar services after cases are confirmed. The University of Tennessee-Knoxville School of Medicine is one of the state's three Genetic Metabolic Centers, providing confirmatory diagnosis for suspected cases in the larger genetic region and treatment for those cases in the specific geographic area. These same medical sites also serve as the regional perinatal center sites.

Middle Tennessee encompasses 39 counties and is bordered by Kentucky and Alabama. The topography ranges from mountains in the east to the Tennessee River on the western edge. Nashville, the capital and second largest city, and two other cities with populations over 50,000 are located in this region: Clarksville, home to the Fort Campbell military base; and Murfreesboro, home of Middle Tennessee State University. This region has Meharry Medical School and Vanderbilt University Medical Center providing program services. Meharry confirms all diagnoses of sickle cell anemia for suspected cases in the state and serves as the Middle Tennessee Regional Sickle Cell Center. Vanderbilt serves as the regional perinatal center and as another of the three Genetic Metabolic Centers confirming diagnoses for the larger region and providing treatment for cases in their specific catchment area.

The western part of the state has 21 counties and is bordered by the Mississippi and Tennessee Rivers and the states of Mississippi, Missouri, Kentucky and Arkansas. This area is part of the Delta, or Gulf Coastal Plain, and is very flat, rural and sparsely populated, with the exception of Memphis, the state's largest city, and Jackson (MSA population 110,400). The University of Tennessee/Memphis Medical School is the third Genetic Metabolic Center confirming diagnoses for the West Tennessee area and providing treatment for cases in its catchment area through the Boling Center for Developmental Disabilities -- an affiliate of the Medical School's Pediatric Department. This site also serves as the perinatal center for the western part of the state.

Population Changes: Using the latest federal census figures, Tennessee's 2000 population was 5,689,283, ranking the state 16th in the nation in total population. During the 1990-95 period, Tennessee's population growth surpassed the increase experienced during the entire decade of the 1980's and outpaced the national average growth rate. During the 1990-99 period, Tennessee was the fourth fastest growing state in the Southeast. The distribution of Tennessee's population by race and sex has not changed significantly in the past several years: For people reporting only one race,

15 percent were black, 82 percent were white, 1 percent was Asian, and 1 percent was of other races. Tennessee's population is 48.7 percent male and 51.3 percent female, with 8 percent minority males and 9.3 percent minority females.

Tennessee is expected to gain 97,000 people through international migration between 1995 and 2025 and is expected to gain 845,000 people through internal migration for the same time period. The population over age 18 is expected to grow from 3.9 million to 5.2 million in 2025 while those classified as youth (under 20 years old) will decline from 27.7% in 1995 to 23.8 % in 2025. The elderly population is expected to accelerate rapidly. All ethnic and racial groups are expected to increase during this time period except for non-Hispanic whites. African Americans, Asians, and persons of Hispanic origin will experience the greatest gain.

In 2000, 25 percent of Tennesseans were under the age of eighteen. Females aged 10-44 make up 25.4 percent of the total population. This reproductive age female population peaks within the 35-44 age group. The two largest population groups are reproductive age women and children under 18 -- the target population served by MCH. This has implications for outreach and recruitment efforts as well as for types of services offered.

Continuing the trend established in the mid-1980s, Middle Tennessee counties led the state's recent growth, with an average increase of 16.5% between 1990 and 1998. East Tennessee counties were next, with 6.9% growth, followed by the West Tennessee counties, which experienced a 5% net increase. Metropolitan counties (defined as those within a Metropolitan Statistical Area [MSA]) grew an average of 11.5% between 1990 and 1998.

Slightly more than a quarter of all Tennesseans live in the four largest cities. Just over 68% of Tennessee's population resides in the state's seven MSAs, five of which are in the eastern two-thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee.

Ethnicity: Less than three percent of the people living in Tennessee in 2000 were foreign born, although the state has experienced a 169 percent increase from 1990. Of the foreign-born population, approximately 40 percent are of Latin American origin, and almost a third are of Asian origin. Hispanics are the largest ethnic minority in Tennessee. According to the 2000 Census, 123,838 persons, or 2.2 percent of all Tennesseans, identified themselves as being of Hispanic origin. The Hispanic population is most likely larger than the reported number due to the growing population of migrant workers and undocumented residents across the state.

Tennessee has a wide variety of ethnic groups in addition to Hispanics. Southeast Asians are the second largest group (52,564), and the state is the fifth largest Kurdish resettlement site in the country. Refugees and legal immigrants have also been arriving from African, Baltic, Central Asian, and Southeast Asian countries. Among people at least five years old living in Tennessee in 2000, 5 percent spoke a language other than English at home. Of those, 51 percent spoke Spanish and 49 percent spoke some other language; 40 percent reported that they did not speak English "very well."

Tennessee's immigrant and refugee population is concentrated in the Nashville area (50-60%), in Memphis (30%) and in the rural agricultural-based counties in the southeastern and western parts of the state.

These new arrivals face access to care issues; obtaining health insurance is a critical barrier to care. In addition, they may have chronic, difficult to treat health problems that are unfamiliar to health care providers. The language barrier is a very real obstacle to care, as is the mix of cultures with which providers are equally unfamiliar. The cultural factor has a special impact on maternal and child health service delivery. These trends make it imperative for the Department to consider the health issues and implications of caring for this growing population.

Addressing the health needs of the state's growing Hispanic population has focused on the expansion of prenatal care services with culturally competent providers within local health department clinics, as

well as expanding the availability of on-site interpreters and translated materials. The Department contracts with Open Communications International for over-the-phone translation services (mainly for languages other than Spanish) for all rural county health department clinics. The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. MCH staff at the central, regions, and local levels are involved in developing programs and services for these new populations.

**Poverty Level:** Tennessee figures from the 2000 Census show fourteen percent of Tennesseans live in poverty, which is comparable to the U.S. figure. Twenty percent of children under 18 were below the poverty level, compared with 17 percent nationally. Eleven percent of all families and 31 percent of families with a female head of household and no husband present had incomes below the poverty level. Eighteen percent of the households in Tennessee received means-tested public assistance or non-cash benefits.

According to the 2004 Kids Count Data Book, in 2001 (2000 data), 18 percent of Tennessee's children under 18 were in poverty, compared to 16 percent for the United States. Tennessee ranked 34th in the nation on this measure, up from 40th in 1996. Ten percent of children were in extreme poverty (below 50% poverty), compared to 7 percent for the nation. Seven percent of children were without health insurance, compared to 12 percent nationally. While overall poverty rates in the state and in the South have been falling, the condition of Tennessee's children is still a major cause for concern.

**Income:** Tennessee's median household income in 2000 was \$36,265, which is 12.5 percent below that of the U.S. (\$41,433).

**Households and Families:** Of the total Tennessee households in 2000, 69 percent were families and 35 percent had children under 18. Thirteen percent were headed by single women. The new measure of grandparents as caregivers showed 61,252 as having responsibility for their grandchildren under the age of 18. As in most other states, about half of the grandparents who live with their grandchildren are responsible for them.

**Health Statistics Data:** As in the nation and in the other southeastern states, Tennessee rates for infant mortality, neonatal mortality, postneonatal mortality, and adolescent pregnancy have been on the decline. However, low birthweight (LBW), which is a major risk factor for adverse health outcomes for both infants and children, increased in recent years and has remained at 9.2 for the past three years. In 1980, LBW was 8.0 percent; in 2000 - 2002, LBW was 9.2 percent. Another major concern is the disparity in the pregnancy outcomes for the African American and white populations. In 2002, the infant mortality rate for births to African American women in Tennessee was 2.6 times greater than the rate for births to white women. Additionally, the African American low birthweight rate for 2002 was 1.9 times greater than the white LBW rate. This gap has been evident for many years and continues despite the increasing availability of services targeted to these populations. Data for 2002 for adolescent pregnancy (ages 10-17) show the lowest rate recorded since 1975. In 2002, the adolescent pregnancy rate for this age group was 14.1. The rate dropped for both the white and the African American populations; however, the gap between the two groups remains. For 2002, the rate for the African American population was 2.3 times that for the white population. These data show that the MCH programs and services in Tennessee continue to be of great need and that resources must continue to be targeted to the populations in need.

Data on disease trends for sexually transmitted diseases (STD) show that Tennessee has experienced a dramatic reduction in STD morbidity, with the exception of chlamydia, over the past five years. The rise in chlamydia morbidity was due to additional screening within the family planning and STD clinics statewide. Like other STDs, syphilis is reported mostly from the large metropolitan areas. The six metropolitan counties represent approximately 42 percent of the State's population and reported 83 percent of the 557 cases of early syphilis cases in 2002. Nashville and Memphis reported 76.5 percent of the state's total cases. The 2002 data show a significant decrease in cases since 2000 (1,159 cases).

The number of gonorrhea cases has declined from a record high rate of 817/100,000 in 1976 to 169/100,000 in 2002. This rate compares to 177/100,000 in 2001. The metropolitan counties have consistently accounted for 81-85 percent of the state's morbidity.

Reported cases among 15-29 year old persons represented 88 percent of chlamydia morbidity in 2002 (14,094 cases out of 16,032). Females comprised 79 percent of all reported cases, clearly reflecting the selective use of limited testing resources. Total cases increased to 20,181 in 2003, a 25.9 percent increase. Data on chlamydia screening in the family planning and sexually transmitted diseases clinics for 2003 show positivity rates for the African American population at over twice that for whites (18.3% and 7.5%). Seventy-four percent of the positive cases in these clinics were persons ages 24 and under. Screening and treatment are provided statewide through these clinics. Changes made to the chlamydia screening program, a joint effort of MCH/Family Planning, the STD program, and the State Laboratory, include working with TennCare to implement the chlamydia HEDIS measure as a required quality of care monitoring indicator for the managed care organizations effective January 1, 2003, upgrading the screening test to the Aptima Combo test (new Gen-Probe amplified test), and approving the use of directly observed therapy. The change to the amplified test has greatly increased the number of positive results.

Targeted services to decrease syphilis continue in Nashville and Memphis. Counties with the highest overall STD rates are in the western part of the state, which has a high percentage of minority residents. The Department continues to place significant emphasis on STD screening, outreach, and treatment, including chlamydia, gonorrhea, and syphilis, with clinic services available in all counties and targeted outreach in the metropolitan counties.

The confounding issues of race and poverty contribute to some of the more serious health problems and health status indicators in the state. The following is a summary of significant issues the Tennessee Department of Health (TDH) is addressing through local health department services and state health initiatives focused on women, infants and children.

African-American adolescents have a disproportionately higher pregnancy rate than white adolescents in all age groups - being addressed through the state's Adolescent Pregnancy Prevention Program, the Abstinence Only Education Program, general health education, family planning clinics and EPSDT screenings offered through the local health departments.

A higher number of minority women are likely to enter prenatal care after the first trimester of pregnancy - being addressed through TennCare enrollment of pregnant women, home visiting services, public-private partnerships, special initiatives through the Regional Health Councils, and pregnancy testing and referral available at all local health department sites.

The infant death rate for minorities in 2002 was over two and one half times that of whites. African-American births comprise 21 percent of the total births, but 41 percent of all infant deaths were African-American.

Neonatal mortality rates are three times higher for African American infants than they are for white infants. Local health departments are using the HUGS home visiting program for special outreach and follow-up for high-risk pregnancies and high-risk neonates. The local health department serves as a first point of contact for TennCare enrollment under presumptive eligibility for pregnant women. The Healthy Start Home Visiting Program targets first time, high-risk mothers with a special emphasis on teens who are parents. The Perinatal Regionalization system is an established, effective statewide service designed to provide expert consultation about problem pregnancies and to transport the mother and baby to the next level hospital when necessary to improve the health service available to the mother and/or infant. The Campaign for Healthier Babies in Memphis and West Tennessee continues is a strong population based approach, targeting women with media messages and coupon incentives promoting the importance of early prenatal care. The Memphis/Shelby County Health Department received a five-year federal Healthy Start grant to address system issues to reduce infant

mortality in October 2000.

The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. Child Fatality Review Teams (CFRT) reviewed 1,027 (95%) of the 1,082 fatalities of Tennessee resident children under age 18 that occurred in 2001. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death). The manner of death for child fatalities in 2001 was determined by the CFRT to be: natural causes, 72%; unintentional injury (accidental) causes, 21%; homicide, 4%; suicide, 2%; could not determine, 1%; and undetermined due to suspicious circumstances, 1%.

The child fatalities were divided into the following categories by cause of death: non-injury, 72%; injury-related, 26%; other cause not listed, 1%; and unknown, 1%. The greatest number of deaths due to non-injury resulted from illness (N=347) followed by prematurity (N=322). Of the deaths where gestational age was reported, 125 involved extremely premature infants (i.e., less than 23 weeks gestation) and 263 involved gestations of 23 to 39 weeks. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents, 46% of all injury-related fatalities. Firearm and suffocation/strangulation fatalities were the next most common cause of injury-related death, 11.3%. African-American children and children from races other than white were more likely to be involved in an injury-related fatality than white children.

African-American children, more than white children, are diagnosed with elevated blood lead levels. The Childhood Lead Poisoning Prevention Program has received funding from the CDC since 2001 to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

African-Americans are more likely than whites to be obese, not wear seatbelts and have a sedentary lifestyle. African-Americans are more likely to be treated for diabetes and hypertension than whites. The Health Promotion Division has active programs and coalitions to address lifestyle-related health status issues. Special initiatives are sponsored through regional health educators and other collaborating agencies. MCH and Nutrition Sections, with many partners through the Tennessee Healthy Weight Network, are collaborating on a statewide plan to address obesity in children.

LifeStart/LifeStyle Initiative - With an April press conference, the Governor and the Commissioner of Health issued a wake-up call to all Tennesseans to start living healthier and make more responsible health choices. The goal of the "Better Health: It's About Time!" initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. Tennessee consistently ranks near the bottom when you compare the health status of our citizens with other states. The Initiative specifically targets infant mortality, prenatal care, adolescent pregnancy, cardiovascular disease, obesity, and diabetes, and also aims to eliminate racial and ethnic health disparities in these areas. The Department of Health will be working on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intragovernmental strategies to collaborate with other departments in state government. The Department is also forming new partnerships with non-governmental agencies, community-based organizations and the faith community.

Initial steps in developing a framework for the Initiative, which internally is being called "LifeStart/LifeStyle", have involved numerous central office working committees composed of a wide cross-section of disciplines and programs. Selecting from the information compiled by the committees on current services and best practices and recommended strategies for action, the Commissioner has developed a plan of action for the state. Regional and local plans are currently being developed for the Initiative. Action plans for all rural counties include a core set of actions and a list of optional components (each will select a minimum of one additional selective). All rural counties will be

addressing cardiovascular disease, childhood obesity, care coordination, employee wellness, and partnerships in the community. Metropolitan counties have been invited to participate in the Initiative.

**TennCare:** On January 1, 1994, Tennessee made history by withdrawing from the Medicaid program and implementing an innovative new health care plan called TennCare. In order to implement TennCare, Tennessee was granted a waiver as a five-year demonstration project approved by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) under Section 1115 of the Social Security Act. A three-year extension of the waiver was granted through December 2001. Early in 2002, a one-year extension was granted to continue the waiver through January 31, 2003. A set of program modifications for a new TennCare waiver was requested from CMS early in 2002. The new waiver, which replaces the previous TennCare waiver, was approved in May 2002 for an effective date of July 1, 2002.

TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents with income below specified limits and uninsured residents at any income level if they have medical conditions that make them uninsurable. All health care services are provided through a managed care approach with health maintenance organizations (HMOs) providing for medical services, behavioral health organizations (BHOs) providing for mental and substance abuse services, a dental benefit manager (DBM) providing for covered dental services, and a pharmacy benefit manager (PBM) providing for pharmacy services.

Eligibility rules for those who do not qualify for TennCare have changed during the years since the implementation of the waiver and the most recent changes were implemented July 1, 2002. Effective that date coverage is available for:

Medicaid beneficiaries who do not have Medicare (Services for Medicaid/Medicare duals are reimbursed by the State). Effective July 1, 2002, Medicaid coverage was extended to women with family incomes below 250% and who had breast or cervical cancer. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically need eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

Enrolled uninsured children, up to age 19, without access to group health insurance, in families whose income is below 200% of the federal poverty level.

Enrolled uninsured adults, without access to group health insurance, in families whose income is below 100% of the federal poverty level.

Enrolled uninsurable individuals, without access to group health insurance who meet certain medical criteria.

New applicants without access to group health insurance, with family income below 100% of the federal poverty level, who meet the medical criteria for "medical eligibility".

Enrollment is currently open only to those who qualify for Medicaid or who are "medically eligible" with incomes below 100% of poverty. The waiver provides Tennessee with the flexibility to cover the uninsured up to 200% of poverty and the "medically eligible" regardless of income. It also provides for the ability to have open enrollment periods for the uninsured population. Because of the state budget appropriation to the TennCare program, TennCare has not scheduled an open enrollment period and is providing coverage at lower income levels than the waiver provides the flexibility to cover.

As of January 2004, TennCare provides health care coverage to 1.2 million Tennesseans, more than 260,000 of which would not have coverage if not for the TennCare waiver. Eighty-three percent of enrollees are on Medicaid. There are approximately 625,000 children under age 21 enrolled in the TennCare program today. During the last twelve months, 782,057 children were served by TennCare. Twenty-two point six (22.6) percent of the state's total population is enrolled in TennCare. Of the total

births for 2002, 48.9 percent were covered by TennCare.

On February 17, 2004, the Governor outlined major TennCare changes designed to contain runaway growth in spending and to improve the program through better management, including promoting disease management and evidence-based medicine initiatives. His proposal was based on a two-part report by independent consultants who concluded that the state cannot afford TennCare in its existing form. In his speech, the Governor outlined a broad strategy to adjust TennCare benefits and to establish limited co-pays for services and pharmaceuticals. The overall strategy is expected to generate an estimated \$2.5 billion in cost-savings over four years. While the waiver has not been submitted and no absolute decisions have been made, the Governor's announced plan in February would suggest that benefits for children, pregnant women, and the disabled will remain basically the same. The proposal addresses benefits, prescription drug costs, disease management and treatment, safety net services, and a fraud and abuse unit separate from the TennCare agency. Negotiations with the Centers for Medicare and Medicaid Services on the proposed changes have already begun.

The Department of Health, since the inception of the waiver, has played an important role in the TennCare program. In addition to serving as a direct provider of care through contracts with the TennCare managed care organizations, the Department has performed various outreach activities, advocacy services, enrollment and reverification services and EPSDT services for the Bureau of TennCare through interagency agreements. The amount and scope of the agreement has varied throughout the years and is indicative of the ever-changing TennCare program. The Department has adjusted its TennCare activities based on TennCare's needs at the time. The relationship with the two agencies has allowed TennCare to have a local presence in every county and has provided TennCare enrollees a "helping hand" when the TennCare help-lines were not sufficient to address the enrollees' needs.

Currently local health departments are providing in excess of 55,000 EPSDT screenings per year and provide school-based dental services targeted to reach TennCare children. Some health departments who provide primary care services act as primary care gatekeepers for TennCare enrollees. Local health departments determine presumptive eligibility for prenatal patients and women with breast or cervical cancer.

Local health department clinics are an integral part of the health care delivery system in Tennessee. In rural and urban counties, the local health department provides traditional public health services, as well as many TennCare services as a means of assuring access to care for eligible citizens. The local health department has always provided information and referral for county residents on a variety of health care issues. Local health department nurses have provided screening and then enrollment for pregnant women presumptively eligible for TennCare since 1994 and provided outreach and advocacy services for TennCare enrollees since the beginning of the program. Clinics have also been the sites for enrollment of uninsured children and for reverification of eligibility for TennCare; these roles are now being handled by other departments.

The local health departments play a critical role in assurance of access to needed services through approved outreach activities to TennCare enrollees. By agreement with the Bureau of TennCare, county staff bill for advocacy/outreach activities based on the time spent in these activities on behalf of the enrollee. Examples of such activities include assistance in accessing medical care by identifying providers and setting up appointments; reminder phone calls to the enrollee so that appointments are kept; assisting enrollees in understanding the TennCare system and appealing, when a medically necessary service is denied; and educating enrollees about the important concepts of a medical home, a primary care provider, the proper use of a hospital emergency room, preventive health education, rights and services under a managed care system. Enrollment of uninsured children into TennCare is handled by the Department of Human Services (DHS). All counties have DHS offices, and health department staff refer families and assist as needed.

The Department of Health is in the process of developing a community outreach project to increase awareness of the availability and importance of EPSDT services. This project will be a significant

expansion of EPSDT services and will be targeted to a broader population of enrollees than those who are seen by the local health department clinics. The project will have specific components designed to reach teens. The statewide project will use public health educators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

New Children's Care Office Established -- On June 14, 2004, the Governor announced the creation of a Governor's Office of Children's Care to coordinate the wide range of services and supports available to children through state departments and the private sector. The Governor has directed that the office's initial focus will be on the delivery of health care services to children. The current TennCare director has been appointed as the director of the new office.

Current and emerging issues for the Department of Health include: health disparities within the various populations continue to be a major problem; changes continue to occur in the TennCare program; and there are an increasing number of persons with primary languages other than English living in the state. MCH, as well as the entire Department, faces the challenges of delivering culturally competent services in the state.

The mission of the Department of Health is to:

- Promote, protect and restore the health of all Tennesseans;
- Prevent problems that contribute to disease, injury and disability;
- Promote healthy lifestyles through health education;
- Ensure quality health care through licensure and regulation of health professionals and health care facilities; and
- Assure availability of services despite economic and geographic barriers.

Within this broad mission, the Commissioner has set three overall priorities for the Department: eliminating racial disparities in mortality rates and other health outcomes through review of the causes, directing efforts to address these, and improving safety practices and better health education (the LifeStart/LifeStyle Initiative is discussed above); improving diversity in the workplace; and increasing the number of non-traditional partners working with the Department and its programs and projects.

Other Departmental initiatives and activities are addressing the improvement of EPSDT screening rates (a cooperative effort with TennCare); improving access to dental services for children; and using data to identify and improve health services for population in need.

MCH activities in Tennessee have consistently targeted services and activities for the large populations of women and children in need. Public health efforts in the state traditionally target this population of women and children. Recent examples include provision of EPSDT screening in the local health departments under contractual agreement with TennCare; providing EPSDT screening to all children in state custody within the local health departments; assisting with new initiatives for EPSDT; and redesigning the MCH home visiting program to target families in need and to provide services determined to be needed for the greatest number of families within the resources available.

## **B. AGENCY CAPACITY**

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. Title V has played an important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs.

The state has local health departments in all 95 counties that carry out health related programs for women, infants and children. Local health departments operate in collaboration with the county executive or mayor and county commissioners. Metropolitan counties have boards of health which set

general policy for their health departments. Funding for local and metropolitan health departments comes from local, state and federal government sources, third party payers and client fees. Maternal and Child Health funds contribute to the financial base of all county health departments.

Each county has one or more health department sites delivering health services, including family planning, child health, EPSDT, immunizations, home visiting services, care coordination for families with children with special health care needs, pregnancy testing, basic prenatal care, prevention and treatment of sexually transmitted diseases, WIC, and TennCare outreach and advocacy. Other services (primary care, prenatal care, tuberculosis, etc.) are provided at selected sites depending upon need and availability of resources. The Department (TDH) contracts with universities, hospitals and other agencies for services such as perinatal regionalization services, genetics, children's special services, additional family planning sites, abstinence only education and child care technical support services. Primary care services are provided by 11 of the 95 county health departments designated as TennCare primary care providers and provide 24-hour coverage and referral.

While certain basic health services are available at local health departments regardless of health care coverage status, others are negotiated with the managed care organizations (MCOs) based on gaps in the health care delivery system. The Department contracts with those MCOs operating in the rural counties to provide some traditional public health services without prior authorization from the MCO. Other health services can be provided to women, infants and children if individual authorization is approved. Staff are very involved in care coordination and case management to assure that women, infants and children enrolled in TennCare receive the services they need.

#### Description of Children's Special Services (CSS) Program:

State statute defines special needs children as: "Children shall be deemed "chronically handicapped" by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."

Services for children with special health care needs are provided through three components of the CSS Program: (1) medical services, (2) care coordination, and (3) a parent support program called Parents Encouraging Parents (PEP). The first component is for medical services and provides reimbursement for medical care, supplies, pharmaceuticals and therapies for children up to age 21 years who meet medical and financial criteria. To qualify for the medical component, families of the children must have an income of 200% of poverty or less.

Medical services are provided through a network of CSS and TennCare approved providers. Each child enrolled in TennCare is assigned a primary care provider (PCP) by the TennCare MCO to serve as the child's medical home. The CSS program assists families in identifying a medical home for non-TennCare enrolled children. Assessment of medical home and annual well-child screenings are a routine part of the application and recertification process for CSS. Staff coordinate primary and specialty care through the designated PCP and corresponding MCO network.

CSS conducts various multidisciplinary clinics in the regional offices and/or in a university hospital based clinic or other private provider setting. Comprehensive pediatric assessment clinics are only held in 1 of the 12 regions since most CSS enrolled children are also enrolled in TennCare. Better access to primary care providers has reduced the number of comprehensive pediatric assessment clinics needed in the state. In areas of Tennessee where there remains limited access to certain pediatric specialists, CSS continues to provide specialty clinics. Coordination of these clinics occurs between CSS, the PCP and the MCOs. There are 6 special CSS orthopedic clinics offered; the number has decreased due to more participating TennCare orthopedic providers. Since most children have some form of insurance, including TennCare, every effort is made to obtain reimbursement.

Because there are many categories of eligibility for TennCare, all children applying to CSS must also apply for TennCare. CSS provides for, but limits through program policy, some rehabilitation and medical services, such as transplant surgeries and orthodontic treatment.

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Twenty-six percent or 1,623 of the 6,244 CSS enrollees have SSI. Staff contact families with newly diagnosed children and provide information on services available.

The second component of the program provides care coordination services by social workers and/or public health nurses in each county. Services promote family-centered, community-based, culturally sensitive, coordinated care. Care coordinators serve as a liaison for the family to medical and other providers and promote advocacy by the family for their special needs child. Care coordinators may attend CSS clinics, private clinics or multidisciplinary meetings with clients and their families. Care coordination may be offered to children not diagnostically or financially eligible for the medical services component. Because the care coordinators have extensive knowledge of community resources, they are often used as contacts within other local health department programs for information and referral. CSS Care Coordination is staffed through a combination of health department staff and contracts with two rural Community Service Agencies and five metropolitan counties.

The third component is the Parents Encouraging Parents (PEP) Program. There are no medical or financial guidelines for PEP. The purpose is to provide parent-to-parent support by matching trained support parents with the parents of children with a disability or chronic illness who are experiencing a time of crisis or transition, or who are seeking information. Parent consultants are themselves the parents of special needs children. The program provides training for parents, community education, outreach, and group support activities. PEP staff work closely with CSS staff and families to strengthen parent-professional collaboration.

Project TEACH (Together Educating and Coordinating Health) provides coordination of services for CSHCN as well as assistance to schools in accessing third party payments for medically necessary services for school-aged children. The program is staffed by nurses and social workers who coordinate efforts in 45 of Tennessee's 139 school systems. In the 2002-2003 school year, these school systems saved \$3 million by accessing TennCare and insurance for school children needing medically necessary services.

Description of preventive and primary care services for pregnant women, mothers and infants:

All local health departments provide pregnancy testing, counseling, and referral for prenatal care; HIV testing and counseling; WIC and nutrition services; presumptive eligibility for pregnant women for TennCare/Medicaid (pregnant women below 185% of the federal poverty level are eligible for TennCare), and testing for sexually transmitted diseases. Staff assist with referrals to the Department of Human Services, which is responsible for TennCare enrollment. Staff also provide outreach and advocacy services for TennCare enrollees, including assistance in accessing medical care by identifying providers and setting up appointments, reminder phone calls, assisting the enrollee in understanding the TennCare system, assisting with appeals, and educating enrollees about the important concepts of a medical home, use of the primary care provider, and preventive health education. All regions have home visiting services for pregnant women and infants considered to be at risk and in need of such services.

The state's perinatal regionalization system consists of the five regional perinatal centers, making high-risk obstetrical and neonatal care accessible to all physicians and health care facilities statewide. This system provides a mechanism for consultation regarding high-risk pregnant women and infants and a system of referral and transfer, when necessary. The system also provides postgraduate education in perinatal medicine for health care providers. Access to the appropriate level of high-risk

care is facilitated through the agreements among delivering hospitals, physicians and the centers. The perinatal regionalization system has a 21-member Perinatal Advisory Committee staffed by MCH. During FY 2003, there were 13,475 deliveries at the five Regional Perinatal Centers, 4,454 NICU admissions, 1,182 newborn transports, 855 follow-up clinic visits, and 6,770 educational hours provided to health care providers. Staff at the Centers provided approximately 2,409 documented telephone consultations and 21,313 onsite patient consultations.

Family planning services are available in every county at 129 clinic sites (health departments, Planned Parenthood agencies, primary care sites). Services include counseling and education, exams, laboratory tests, and contraceptive supplies, and are available upon request to any reproductive age person. During CY 2003, the program provided services to 110,223 persons.

The WIC Program provides supplemental food items to approximately 155,000 eligible participants each month. Participants are pregnant and breastfeeding women, infants and young children under five years of age who are at risk of poor growth, who meet the required income guidelines. Services to certify participants and issue vouchers for the foods are provided at approximately 140 local health department, primary care, and hospital sites throughout the state. Nutritionists teach individuals or groups proper nutrition for everyday living. Registered dietitians counsel individuals with special dietary needs such as hypertension, diabetes and weight management. Breastfeeding classes and support are also available statewide.

The state's Genetics and Newborn Screening (NBS) Program requires by law that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases, including sickle cell. The MCH NBS follow-up nurses are located at the State Laboratory to assure that all abnormal results are reported as quickly as possible. The program involves cooperation between birthing hospitals, the State Laboratory, the MCH Program staff, the Genetic Centers, Sickle Cell Centers and primary care physicians. The state is currently testing 19 different metabolites which relate to 29 types of genetic disorders. The state will begin screening more analytes which will reflect up to 42 different genetic disorders which equate to 61 different genetic diseases by the end of the year. For additional information, see NPM #1.

Newborn Hearing Screening - CY 2003 data indicate that 86 of the 89 birthing facilities provide hearing screening to 97% of the birth population. Seventy-five facilities currently report hearing screening results on the state metabolic/genetic blood spot form. Facilities are encouraged to provide screening for all newborns. Education for providers and families is provided. The Tennessee Newborn Hearing Screening Program (NHS) monitors the progress of birthing facilities that provide universal newborn hearing screening. The Department was awarded a HRSA Newborn Hearing Screening Grant in 2001 and a CDC Early Hearing Detection and Intervention Tracking, Research and Integration Grant in 2001. The goal to increase the number of hospitals that provide universal hearing screening programs is ongoing. The rate of follow-up for infants referred for further hearing screening increased from 24.4% in CY 2002 to 42% from January-June 2003, and then to 93.7% from July-September 2003. The increased rate was due to the implementation of follow-up services by the Tennessee Early Intervention System (TEIS) through a cooperative agreement with the Department of Education, IDEA Part C program. For additional information, see NPM #12.

Additional services for infants are described in the following section.

Description of preventive and primary care services for children:

Child Health - The Department strives to insure that all children and adolescents receive needed preventive health services through outreach services that help them access their primary care provider or by providing direct services. All local health department clinics provide child health services, including EPSDT screens and immunizations. The Child and Adolescent Health Manual provides technical assistance on providing quality health care services. The manual includes a

section on anticipatory guidance which staff use to provide information to parents and empower them in their role as parents. Eleven county health departments are contracted by the TennCare MCOs to provide gatekeeping and primary care services for a caseload of 13,600 enrollees. Many of these are children.

EPSDT - All TennCare recipients under age 21 are eligible for preventive health care screenings under EPSDT. The Department helps insure that all TennCare children are receiving this important health care service. TennCare requires every MCO to contract with local health departments for EPSDT screening services. The local health departments provided 43,512 EPSDT screenings in FY 2002 and 51,845 in FY 2003. It is projected that 60,000 screenings will be done in FY 2004. Effective June 2003, the Department assumed responsibility for screening all EPSDT eligible children in the custody of the Department of Children's Services (DCS). Data for April 2003 -- March 2004 show that 90.4% of children had completed EPSDT appointments within the past year (8917 children).

Child Care Resource and Referral Centers (CCR&RC) -- There are more than 5,600 regulated child care providers with a capacity to serve more than 332,000 children. The staff of the 11 Centers include child care health specialists as well as specialists in other areas related to child care, who are available to assist all child care providers. Although the direct services are mainly provided to child care providers, many of them relate to the prevention of health and safety problems for the children they serve. MCH provides partial funding for the salaries of the health specialists and provides training on health and safety issues for CCR&RC staff. This past year, the Child Care Health Consultant in MCH provided a total of three days of training for staff in addition to one-on-one technical assistance at each of the Centers.

Adolescent Health -- An Adolescent Health Leadership Team comprised of all state health department staff who work with adolescents meets quarterly to implement strategies designed to enhance the overall health of youth; to promote services and policies that are formed from a holistic youth development approach; to address health disparity issues among adolescents; to create partnerships with local, state, federal, foundation, academic and statewide organizations across a broad range of adolescent health issues; and to track and assess the 21 Critical Objectives for Adolescent Health, Healthy People 2010. An adolescent health data report has been drafted and will be released in fall 2004; an adolescent health survey has been developed and distributed to public and private providers of adolescent health; 4 out of the 30 planned youth health focus groups have been conducted; nurses from each health region attended an Adolescent Health Care training conference in Boston; and a systems capacity for adolescent health assessment tool was piloted in conjunction with AMCHP and the State Adolescent Health Coordinators Network. Youth obesity, youth suicide, youth violence prevention activities, and promotion of positive youth development practices were implemented this year.

Childhood Lead Poisoning Prevention Program (CLPPP) - The Department of Health received three one-year grant awards from the CDC to implement CLPPP beginning July 1, 2001. The overall goal is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Program goals are: a) Monitor all blood lead levels of children less than 6 years old; b) Increase screening of children at high risk of lead exposure; c) Assure proper follow-up for children with elevated blood lead levels; and d) Increase public awareness of childhood lead poisoning and prevention. CLPPP resources are targeted to areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units. Additional information is in SPM #2.

Dental Services -- The efforts to expand access to dental services for children began in spring 2001. Clinical dental programs were enhanced through one-time special needs grants; currently, 60 out of 95 counties have dental clinics. Preventive dental services are provided statewide through a contract with TennCare which funds the School Based Dental Program. Last year dental screenings were provided for 102,753 children in 297 schools. Three mobile dental clinics are providing comprehensive dental services to children in remote underserved areas. Additional information on dental services for children is in NPM #9.

**SIDS** - The SIDS program includes making autopsies available for every suspected SIDS death and providing support to parents and their families through published materials, home visits by a public health nurse, and referral for counseling and association with parent groups of those who have experienced a SIDS death. A new law states that the Department of Health with the Department of Children's Services will train first responders (Emergency Medical Technicians, professional firefighters, and law enforcement officers) in conducting the Death Scene Investigation of the sudden, unexplained death of a child. This training must include information about SIDS and responding to a grieving family. Prevention Through Understanding: Investigating Unexpected Infant Death, the Death Scene Investigation Project, has accomplished much during this fiscal year through a contract with Middle Tennessee State University. In April a Death Scene Investigation In-service for Trainers was conducted in Knoxville. The curriculum manuals and the in-service program have been approved for in-service and pre-service training by the Commission for Law Enforcement, the State Commission Board for Fire Fighters and the Board of Licensure and Education for Emergency Medical Services. "Prevention Through Understanding" has been approved for five contact hours for trainers who go through the program and for two contact hours for trainees who attend a trainer in-service or pre-service program.

**Help Us Grow Successfully Program (HUGS)** - Program goals are to prevent or reduce complications of pregnancy, subsequent unplanned pregnancies, developmental delays in children, and maternal and/or infant morbidity and mortality through home visiting services and a case management model. Services are targeted to prenatal and postpartum women up to two years after delivery (including women who have lost a child due to miscarriage, stillbirth, prematurity, SIDS or other causes) and children birth through the age of 5 years. These services assist this population in gaining access to health care (well-child checks, immunizations, EPSDT, WIC, etc.), psychosocial, educational and other necessary service to promote good health practices and improve general well-being. The program has recently expanded services by working with the Child Fatality Review staff to receive referrals and provide services to women who have lost a child under age two due to death. Services are provided to assist these women and their families cope with the grieving process and improve the outcome of future pregnancies. 22,851 visits were made in FY 2003 and 32,467 in FY 2004.

**The Child Health and Development Program (CHAD)** began with Appalachian Regional Commission funding in the early 1970s. It continues today in 23 counties. Services are targeted to pregnant women under age 18 and families with infants and small children in the designated counties. CHAD provides education, assessment, and support to 1,400 families annually.

**The Healthy Start program** began in 1994 with the passage of state legislation to replicate the Hawaii Healthy Start model of home visiting. Contract agencies provide these services in 26 counties. This home visiting program provides intensive services to families at risk of child abuse and/or neglect. Families receive child development education as well as general support and parenting education. Healthy Start provides intensive home visiting services to approximately 1,600 families per year and provides assessment and referral services to hundreds of additional families.

**School Health** - In 2003, Tennessee began the process of Medicaid reimbursement for TennCare School-Based Health Services. Coordination among staff in all agencies has been important to prevent the duplication of services and to insure that EPSDT requirements are met. MCH staff also serve as a resource to school nurses across Tennessee on health and safety. The department shares the responsibility with the Department of Education to develop and maintain current Guidelines for the Use of Health Care Professionals for Administration of Medication and Health Care Procedures In a School Setting. These guidelines are updated to reflect legislative changes. The changes for the 2004 legislative session will include care of children with asthma and diabetes and the requirement for current CPR certification for school nurses.

**EMS for Children** - MCH staff coordinate on services for pediatric emergency care by working with the Children's Emergency Care Alliance and the State Committee on Pediatric Emergency Care. This committee also provides oversight of the poison control center grant programs in Tennessee. The Middle Tennessee Poison Center at Vanderbilt University Medical Center is now the only such center,

taking calls from throughout Tennessee with the January 31, 2004, closing of the Southern Poison Center at the University of Tennessee Health Science Center in Memphis. The volume of calls at the Vanderbilt center is expected to increase from 66,000 calls to 96,000 calls annually. The state EMS Training Coordinator is a member of the advisory committee overseeing the contract with MTSU to provide an annual training and training materials on the Death Scene Investigation of sudden infant death and was a speaker at the most recent training.

Abstinence Only Education -- MCH is responsible for the administration of the Abstinence Only Education Program. The federal funds are being used to support 22 projects in community-based organizations in 17 counties. A statewide conference for providers and community groups working with youth has been held annually since September 1999. The program director also provides technical assistance to a wide variety of agencies and staff across the state in the area of abstinence education.

Tennessee's welfare-to-work program, called Families First, imposes work requirements, time limits and parental responsibilities on recipients. Families First participants who lose eligibility for any reason other than successful transition to self-sufficiency are offered a home visit by local health department staff to determine if the health or safety of the family is in jeopardy. The home visit provides general health assessments of each family member and referrals to appropriate providers. The home visiting component is coordinated with the Department of Human Services (DHS). The Department of Health handled 14,539 referrals for Families First home visits. Of this number, 29% of the families received assessment visits, 16% refused the home visit, and 61% received a home visit attempt as well as written and telephone contact attempts.

Early Childhood Comprehensive Systems Program -- MCH received a planning grant on June 1, 2003, to create a network of representatives from state departments, public and private agencies, parents, advocates, representatives of faith-based organizations and business communities and to develop strategies for evaluating current systems and creating an implementation plan addressing the five critical elements of the grant. The Department has contracted with United Way to implement the grant activities. Working cooperatively, staff have selected early childhood care indicators, are collecting data, and beginning agency inventories.

Description of culturally competent care appropriate to MCH population:

Language barriers pose challenging communication issues at almost every level of the health care delivery system. The continuing increase in Spanish speaking populations has created a critical need for appropriate language services by health care providers across the state. The Department contracts with Open Communications International (OCI) to provide over-the-phone translation services (mainly for languages other than Spanish) for rural health department clinics. Assistance with over 170 different languages is available. Through a toll-free number, interpreters can be accessed 24 hours a day. OCI has provided materials to all health departments to inform non-English speaking clients of this service and allow them to visually indicate their preferred language.

The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. The Department has developed and implemented Title VI Policies and Procedures for limited English proficiency, which are applicable to all Health Services Administration programs that are receiving federal financial assistance. Topics covered include data collection, analysis and reporting, oral language interpretation, translation of written materials, providing notice to LEP persons, staff training, and quality management.

A variety of staff training and activities have occurred across the state: Chattanooga-Hamilton County formed a special LEP committee to focus on language barriers, standards for translation service providers, job description for paid interpreters, and a mechanism to test proficiency of interpreters and translators. Knox County has a 15-week Spanish course for their employees. CSS staff recently attended training on cultural competence held by Georgetown University.

State statutes relevant to Title V program authority are:

The Crippled Children's Act establishes services for children with special health care needs who meet income and diagnostic guidelines and an advisory committee.

The Genetics and Newborn Screening Act establishes the program responsible for screening and follow-up with all babies born who have questionable or confirmed lab results for genetic and inborn errors in metabolism. The required screening tests are defined by Rules.

The Child Fatality Review Act requires that review teams be established in each judicial district and that all deaths to children under the age of 17 are reviewed, that an annual report is written, and that a statewide advisory group is convened at least annually by the Commissioner to review findings and recommend policy.

The Welfare Reform Act requires that the Department, through local health departments, provide home visiting services to families with young children within 30 days of termination from the Families First program for reasons other than self-sufficiency.

Establishment of the Hawaii model of Healthy Start for families at risk of child abuse and neglect.

The Family Planning Act established the statewide family planning program, including availability of contraceptives, eligibility for services, disposition of funds and services to minors.

Other MCH-related statutes are implemented in other areas of the Department. The Traumatic Brain Injury Program establishes the head and spinal cord injury information system and advisory council; a statewide public awareness campaign for shaken baby syndrome is addressed jointly by the Departments of Health and Human Services. Tennessee was one of the first states to legislate child safety through the required use of child safety seats. The Child Bicycle Safety Act requires all operators and passengers under the age of 16 riding on a state roadway to wear approved protective bicycle helmets and defines additional requirements for other riders. Statute declares it an offense to transport a child under 6 years old in the bed of a pickup truck on any roads of any county or state highway.

Legislation from the 2004 session included: (1) requiring the Board of Education, in conjunction with the Departments of Education (DOE) and Health (DOH), to write rules setting minimum nutrition standards for the sale of individual foods in school vending machines or other sources in grades K-8 and implement these standards by fall 2005; (2) requiring all persons riding in a motor vehicle to be properly restrained and making all motorists subject to being stopped and ticketed for not wearing a seat belt; (3) TennCare reform legislation giving the Governor authority to limit benefits and impose co-payments in a major cost-saving plan while maintaining maximum benefits for pregnant women and children; (4) permitting trained volunteers to assist students with diabetes, excluding insulin administration, based upon a medical management plan approved by parent and medical provider. Also requires all school nurses to be trained in diabetes care and be aware of diabetes guidelines to be issued by jointly by DOE and DOH; (5) allowing public health nurses to apply fluoride varnish on the teeth of at-risk underserved children; (6) created a legislative study committee to review data on cervical cancer and human papillomavirus of women, evaluate current outreach efforts, access to screening and ways that screening accuracy can be increased; (7) established a legislative task force to study violent deaths of children and make recommendations by January 15, 2005; (8) allowing a health care provider to indicate the possible need for a dental or vision examination on the immunization status form submitted to the child's school. The provider is to provide a copy of the form to the parent/guardian; (9) adding additional fines to four moving violations and directing the additional revenue to the Traumatic Brain Injury Program to expand services and assistance to persons and families affected by brain injuries; (10) requiring school nurses to maintain CPR certification and directs DOE to complete a survey of local education agencies concerning the number of full-time volunteer employees who have CPR certification; (11) requiring a local education agency to permit any student to possess and self-administer medication from a prescribed, metered dose, asthma-

relieve inhaler if parent has authorized and health care provider asserts the child is asthmatic and has been instructed in self-administration; (12) requiring Department of Environment and Conservation to maintain a list of meth labs that have been raided and authorizes a law enforcement agency, with court approval, to "quarantine" the property for future habitation until and unless the property is cleaned by an approved contractor and attested to by an independent certified industrial hygienist.

## **C. ORGANIZATIONAL STRUCTURE**

The Tennessee Department of Health is a branch of state government with a commissioner appointed by the Governor. There are thirteen regions under the state health department serving the 95 counties. Seven of the regions are comprised of rural counties, and six are comprised of metropolitan counties under the jurisdiction of metropolitan city councils/government. The counties in the seven rural regions are a part of the state's administrative system, whereas the six metropolitan counties are a part of the county administrative systems. Each county has a local health department with at least one clinic site. The central office of the Department, including Maternal and Child Health, functions as the support, policy-making, and assurance office for the public health system. Central office program staff work closely with staff in both rural and metropolitan regions on all program activities. The primary difference between the two types of regions is the method used to provide funding. Rural regions are part of the state government system, and metropolitan counties are separate city/county government systems. Both operate maternal and child health programs using the same standards and guidelines. The central office provides support and technical assistance to both rural and metro regions.

The Department of Health has a range of responsibilities, including administering a variety of community-health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into four bureaus and seven support sections. The Bureaus are Alcohol and Drug Abuse Services, Health Licensure and Regulation, Health Services, and Administrative Services. The support sections include the State Laboratory, Office of Minority Health, Office of Policy, Planning, and Assessment, Office of Human Resources, Office of General Counsel, Office of Communications, and Office of Information Technology. The Maternal and Child Health Section is in the Bureau of Health Services with those other sections providing services across the state (Communicable and Environmental Disease Services, WIC/Nutrition Services, Community Services, General Environmental Health, HIV/STD, Medical and Dental Services, Regional and Local Health).

MCH consists of two components: (1) Child Health, consisting of Child and Adolescent Health Services and Children's Special Services, and (2) Women's Health, consisting of Genetics and Newborn Screening Services and Women's Health. Organizational charts for the Department, the Bureau of Health Services, and Maternal and Child Health, including Services for Children with Special Health Care Needs, are available upon request.

The administration changed with the election of Philip N. Bredesen as Tennessee's 48th Governor in November 2002. In February 2003, Governor Bredesen named Kenneth S. Robinson, M.D., to serve as the Commissioner of Health. Dr. Robinson, a physician and minister, also has served as Assistant Dean for Admissions and Student Affairs at the University of Tennessee, College of Medicine, and taught and practiced internal medicine for 10 years at Vanderbilt University. Dr. Robinson is a national authority in developing community-health and wellness programs through churches and nonprofit organizations.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN). The state has local health departments in all 95

counties, established by state mandate, that carry out health related programs for women, infants and children. The Department of Health is responsible for the overall administration of the Maternal and Child Health Block Grant funding and all the programs, projects, and activities which are components of maternal and child health.

Funds that support MCH section activity include several special funding sources in addition to the MCH Block Grant. The state's award for State Systems Development Initiative (SSDI) has been used to develop the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since SSDI funds were used to develop an integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used to upgrade the hardware and software used in the Genetic and Newborn Screening Program, which is under the direction of MCH and fulfills the state mandate to screen every baby born in the state for metabolic disorders.

The section has administered a Community Integrated Service System (CISS) -- Health in Child Care grant. These funds were combined with funds from the Child Care Licensing Division of the Department of Human Services and the Developmental Disabilities Council to fund Child Care Resource and Referral Centers (CCR&RC) in the Department of Human Services (DHS) regions of the state. There are currently 11 Child Care Resource and Referral Centers statewide serving approximately 5,250 regulated child care providers who provide care for 331,230 children. These centers provide technical assistance to all child care facilities in their geographic areas with the goal to improve developmentally appropriate practices; address health and safety issues in child care settings; and increase inclusion of children with special needs in established child care programs. Tennessee was also successful in competing for CISS-Child Care grants requiring training of child care health consultants who are associated with the established child care resource and referral centers. CISS grant funding is used to replicate the child care health consultant training developed by UNC -- Chapel Hill for these staff persons. Each of the CCR&RCs employs a professional who serves as a child care provider specializing in health. During 2003, 13,896 participants, not unduplicated, received 30,264 hours of training on child development, early childhood education, health and safety, developmentally appropriate behavior management and child care administration through the Tennessee Child Care Provider Training (TN-CCPT). Each licensed child care provider also receives an annual on-site visit from a CCR&RC specialist. MCH has allocated \$100,000 from the Block Grant as one portion of continuation funding for the centers and to support CCR&RC positions. CISS funding is used to support the training of CCR&RC staff.

The state's Abstinence Only Education Program is under the direction of MCH. The federal funds supporting this program are being used to support 22 projects in community based organizations in 17 counties. A statewide fall conference on the importance of abstinence until marriage and character education for school aged youth has been held annually since September 1999.

The CDC-funded Childhood Lead Poisoning Prevention Program is under the direction of MCH. Funding has been received since 2001 for providing screening, follow-up, education of providers and the general public, and surveillance/data collection in 94 of the 95 counties (excluding Shelby). Effective July 2003, a three-year cycle of funding from the CDC combined the two programs into one statewide effort. In 2002, 40,466 children ages 6-72 months were screened; 811 had a confirmed blood lead level >10 ug/dl. For 2003, 51,595 children ages 6-72 months were screened; 199 had a confirmed blood lead level >10 ug/dl.

MCH also is responsible for the Title X family planning program which provides comprehensive family planning services in all 95 counties through 129 clinics, including local health department clinics, Planned Parenthood agencies, and primary care centers. For 2003, the program served 110,223 clients, of which 81 percent were at or below 150 percent of the federal poverty level.

The HRSA-funded Newborn Hearing Screening Grant is administered by MCH staff. The fourth funding year for Tennessee's Health Resources and Service Administration (HRSA), Universal

Newborn Hearing Screening Program (UNHSP) Grant CFDA# 93.251 began March 31, 2004. Completion of the goals and objectives of the four year grant are on track. The focuses for the third year were to provide education for the physician and audiology communities; provide and develop resource materials for parents and families of infants identified with hearing loss; and increase the number of infants obtaining follow-up services. The fourth year grant is focusing on the development of guidelines and training on pediatric audiologic assessment and amplification and on extending access of newborn hearing screening to infants born in the home.

MCH administers the Child Health and Development (CHAD) Program that is funded by the Tennessee Department of Children's Services to provide home visiting services primarily to families of abused or neglected children (or those at risk of) in 23 counties.

MCH received an Early Childhood Comprehensive Systems (ECCS) Planning grant June 1, 2003, to create a statewide network of partners to evaluate the current systems capacity, conduct a statewide needs assessment, prioritize identified problems areas, and develop an implementation plan. Transitioning of the CISS grant and sustainability of the Early Childhood Comprehensive System are included. The Child Care Resource and Referral Center staff will be an integral part of the ECCS development. MCH is contracting with United Way for implementing the objectives of the grant. An evaluation consultant has been hired and with the project director and MCH has selected 26 possible indicators to address trends in early childhood care. An internal scan and agency inventories will be completed to assess the overall state capacity to deliver a seamless system of care and used as a basis for the development of the statewide strategic plan. This plan will be provided to private entities that sponsor early childhood programs to solicit support, and possible corporate sponsorship, for these efforts and for sustainability.

#### **D. OTHER MCH CAPACITY**

The Maternal and Child Health section, like other sections of TDH, is organized into three levels of administration and service delivery. The Central Office, consisting of a staff of 31 professional and office support personnel, addresses strategic planning, policy development, program management, contract monitoring and data analysis functions. The seven rural regional offices are responsible for the health services offered in a specified geographic area (between 10 and 14 counties), and the metropolitan regional offices are responsible for the health services offered in each metropolitan county.

Staff are primarily located in the Cordell Hull Building in downtown Nashville which houses all the central office administrative offices of the Department, including the Commissioner's office and the Bureau of Health Services' central office. Those MCH staff responsible for newborn screening follow-up are located at the State Laboratory, in Nashville but approximately six miles from the downtown office.

At both the central office and regional level, staff administer the programs mandated for women, infants and children and handle all the administrative functions including personnel management, fiscal management, systems development for the Patient Tracking Billing Management Information System (PTBMIS), outreach and coordination with other health service systems including TennCare. Staffs at the regional and local health department levels are under the supervision of the regional director and his/her staff and are not considered out-stationed central office staff.

Within central office, the Maternal and Child Health Section is organized into four primary areas of health issues under the direction of Theodora Pinnock, M.D. Dr. Pinnock is a pediatrician and completed a fellowship in developmental and behavioral pediatrics. She has had extensive experience working with a wide variety of agencies, developmental centers, community projects, and universities. Dr. Pinnock was hired as the MCH director April 22, 2003. Her curriculum vitae is in the attached file.

The four areas of MCH are as follows, with brief descriptions of the identified Program Directors.

Women's Health Services -- Margaret F. Major, MPA, RD, serves as Program Director and has worked in public health programs related to women and children since 1969. After 3 years of working in Brazil with international nutrition programs, she joined the Tennessee Department of Health in 1972, working in community nutrition programs, maternal and child health, family planning and women's health. Her current program responsibilities include family planning (Title X), perinatal regionalization, prenatal care, and the adolescent pregnancy prevention program.

Child and Adolescent Health Services -- Judith Womack, RN, serves as the Child and Adolescent Health Director. She has 25 years of service in public health working in a variety of capacities at all levels of health service. She has diverse experience managing and coordinating a broad array of programs with the maternal and child health and health promotion fields. Her curriculum vitae is in the attached file.

Children's Special Services (CSHCN) -- Greg Yopp, BSW, has served in a variety of roles working with children over the past 20 years. His career in public health has been solely with Children's Special Services. Over twelve years ago, Mr. Yopp began working as a Care Coordination Supervisor for CSS in rural West Tennessee. He came to Nashville in 2000 as Program Director for Care Coordination. Mr. Yopp was named State CSS Program Director in February 2002.

Genetics and Newborn Screening Services -- Mitzi Lamberth, RN, MSN, joined the Department in 1996 as the Newborn Screening Program Coordinator, and is currently the director of Genetics and Newborn Screening Services. Ms. Lamberth holds a Masters of Science degree in Nursing. Prior to her service with the Department, her focus was nursing in the hospital setting at Vanderbilt University Medical Center. She has been with the MCH section since 1996.

Organizationally, within the MCH Section, team leaders have been established. Judith Womack serves as the team leader for Child and Adolescent Health and Children's Special Services. Margaret Major serves as the team leader for Women's Health and Genetics and Newborn Screening.

Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment. This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. These data sets include WIC, birth files, death files, linked birth-death files, hospital discharge, and the birth defects registry. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in both Health Services and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and hearing screening are handled through the Neometrics system for MCH and the State Laboratory.

Role of parents: In the Parents Encouraging Parents (PEP) component of the Children's Special Services Program (CSS), volunteer support parents are trained and are matched with parents of CSHCN who are experiencing a time of crisis or transition or are seeking support from other parents who have a child with the same or a similar diagnosis. PEP offers parents of CSHCN a support system that is family-centered in which they can share common experiences. PEP currently has a state level program coordinator, 2 Regional Program Coordinators and 1 Parent Consultant. One of Program Coordinators and one of the Parent Consultants resigned this year, and due to our state's hiring freeze, have not been replaced. Care Coordinators are assisting families with referrals for needed services to available community agencies or referring to a PEP coordinator in another region. Plans are under development to contract with a nonprofit agency for these services in selected geographic areas. A consideration of employment for the PEP parent consultants is that they are a parent of a CSHCN. In the first three quarters of FY 2004, there were 50 new matches between PEP parents. PEP staff received 141 referrals and provided 325 follow up contacts. PEP made 58 referrals to the CSS program or to other agencies.

Two parents serve on the CSS Advisory Committee for the program.

Parents of children with hearing loss have participated in the Newborn Hearing Screening Program since 1997. Since February 2002 the program has contracted with Karen Dockery through Family Voices - Tennessee for 0.5 FTE Parent Consultant to assist with the development of family friendly educational materials and participate in the development and implementation of program policies, protocols, and in-services. This parent of a hearing impaired child has experience in writing and publishing as well as counseling. She contacts individual families for support, works closely with parents of infants and toddlers with hearing loss to present their personal stories on several parent panels, and chairs the NHS Task Force Parent Committee. The program had 14 parents involved with two statewide trainings held in September 2003 in two separate locations. There are 6 parents on the NHS Task Force. Ms. Dockery was the team leader for the development of four newborn hearing related brochures printed in 2004. Two brochures were written for parents, and two of the brochures target professionals and are written from a parent's point of view. Two parents of children with hearing loss attended the February 2004 HRSA/CDC EHDI Conference.

The University of Tennessee Genetics Center has been the recipient of a genetics planning grant from HRSA and is currently the recipient of a grant for statewide implementation (Integration of State Health Information Systems and Newborn Screening Service Systems). This grant involves staff from MCH, the Office of Policy, Planning, and Assessment, and all genetics centers, a representative from a regional perinatal center, consumers, and others. The structure involves seven committees advising the direction of the project. Three parents of special needs children serve on several of these committees, including the consumer, ethics, and data collection committees.

## **E. STATE AGENCY COORDINATION**

Maternal and Child Health staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, with other governmental departments and agencies, and with organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, and the Arthritis Foundation). The following information provides examples of these collaborative activities.

MCH has always had a strong collaborative relationship with metro health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through a multi-service contract. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in service training and planning meetings about MCH programs and services. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities in the chain of command is that metros report to boards of health and the mayor, while rural regional directors report to the Deputy State Health Officer of the Department of Health.

TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. Project TEACH staff work with TennCare, Managed Care and Behavioral Health Organizations and providers, and the Department of Education in providing medically necessary services to children enrolled in local school systems, including coordination of services and providing outreach to the child's family, encouraging them to access appropriate TennCare services. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network

providers for CSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services. All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees. The genetics director is working with the TennCare MCO medical directors on the changes occurring in the metabolic screening program.

Department of Children's Services (DCS): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include participation with the Child Fatality Review program at both local and state levels and funding both the Healthy Start and Child Health and Development home visiting programs. CSS regional coordinators and Project TEACH staff work with the DCS regional Health Unit nurses to coordinate health services for CSHCN in state custody.

MCH staff are members of the Children's Justice Task Force and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse.

Department of Human Services (DHS): The local health departments receive referrals from DHS as part of the Families First welfare program. Families that unsuccessfully terminate the program are referred to the Department (DOH) for home visits in an effort to ensure that families will survive adequately without the Families First funds. The DOH home visitors assess the families, refer them to any needed services and submit reports to DHS. DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices currently serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State.

Department of Education: The directors of adolescent health and child and adolescent health serve on the advisory committee of the Coordinated School Health Pilot (CSHP) Program. Also, the director of adolescent health is partnering with the CSHP director to provide an assets building training project with representatives from the 10 CSHP pilot sites in fall 2004. Staff are working with the CSHP director to plan school-based child obesity prevention programs in conjunction with the LeBonheur Hospital school health team in Memphis.

See paragraph under TennCare related to Project TEACH. The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 years old identified with or have a potential for a developmental delay. TEIS has been an active participant in collaboration with the CSS program since 1990. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council representing all MCH programs. TEIS staff serve on the NHS Task Force (SICC) and the genetics implementation grant committee and have participated in joint in-services with CSS and NHS. The Tennessee Infant Parent Services (TIPS) program trains Parent Advisors to provide home-based services to infants and toddlers birth to 5 years identified with a vision and/or hearing loss, or other

disability. TIPS and TEIS work closely with the NHS program and provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. The TEIS data collection system documents hearing follow-up and will link to NHS. An MCH staff person serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program Advisory Committee. An MCH Nursing Consultant serves on the TennCare for Children Advisory Committee and the Children's Policy Work Group with the Director of the State Head Start Collaboration office. These committees include state agency staff and advocates for children and meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors, has been invited to attend the MCH video-conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children.

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. Staff from Mental Health and their contracting agencies provide training for Project TEACH staff. CSS nursing consultant serves on the Council on Developmental Disabilities. CSS includes an assessment of a child's psychosocial development and refers CSHCN and family members to local mental health centers or other local MH providers if appropriate. Mental health and social-emotional development are one of the five critical areas that will be addressed in the Early Childhood System of Care, and TDMHDD staff have been asked to participate on the Advisory Committee.

The adolescent health director works with TDMHDD staff to address youth violence prevention activities as a part of a state youth violence prevention committee. This past year over 100 youth violence prevention forum kits were distributed to grassroots organizations throughout Tennessee. The kits provided materials for adults to partner with youth to plan and implement a local forum to address local youth violence prevention issues.

The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth violence prevention. The committee developed a state plan to address youth suicide prevention. Funding is being sought to support the implementation of the plan.

Social Security Administration: MCH staff provide information on MCH programs to parents of CSHCN who have applied for SSI. The CSS program coordinates referral of children whose names are received from the SSA. The parent or guardian is sent information about possible services available to their child from state programs (CSS, Mental Health, Mental Retardation, TEIS, and the regional genetics centers).

Corrections: TN Bureau of Investigation staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CSHCN constructed at no cost to families.

Vocational Rehabilitation: See Department of Human Services.

The Commission on National and Community Service coordinates state volunteer efforts. The adolescent health director represents the Department of Health on this commission. Members include representatives from the public and private sector who are engaged in promoting volunteer services throughout Tennessee. This MCH staff has assisted commission members and staff as they explore the feasibility of Tennessee becoming a "State of Promise" through the America's Promise initiative.

**Child Fatality Review:** The Child Fatality Review process is a statewide network of multi-discipline, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. Members of the local teams include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; judiciary member nominated by the Supreme Court Chief Justice; Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.

**Childhood Lead Poisoning Prevention Program:** Collaborating agencies include: a) University of Tennessee Agricultural Extension Service for social marketing: to develop and distribute exhibits and brochures on childhood lead poisoning to health departments and extension agents; b) University of Tennessee Department of Health and Safety Sciences to analyze child blood lead level data and conduct a statewide baseline survey of Tennessee health care provider practices related to childhood lead poisoning; c) University of Tennessee Memphis for pediatrician experienced with lead poisoning in children to advise staff, partners and health care providers regarding medical case-management of children with elevated levels; and d) Department of Environment and Conservation to conduct environmental investigations.

**Folic Acid Education Campaign:** MCH and Nutrition staff are partnering with the March of Dimes and members of the state and regional folic acid councils to educate the citizens of Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The state folic acid coordinator serves as chair of the state council. The MCH Women's Health director serves on the state council.

**Healthy Start Project --** An MCH staff serves as project support from the central office to the federally-funded Healthy Start project in Memphis and attends the Healthy Start national and regional conferences.

**HIV/AIDS/STD:** There is strong collaboration between the staff of the MCH and HIV/AIDS/STD sections. Family planning staff make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS. With the integration of services at the local levels and the multiple functions performed by staff in the clinics, staff are very familiar with MCH and HIV/AIDS/STD programs. The Infertility Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory.

**The Tennessee Breast and Cervical Cancer Early Detection Program (TBCCEDP):** Seeking to educate women in Tennessee about the need for cancer screening, TBCCEDP coalition, consisting of private and public providers and advocates, meets twice a year to prioritize needs and seek solutions; central office MCH staff participate in these meetings. Regional MCH staff work closely with TBCCSDP coordinators.

**Office of Nursing:** MCH central office nursing staff provide program updates and serve as consultants to the regional nursing directors at their quarterly statewide Nursing Directors' meetings. The women's health nursing consultant serves as a consultant to the Public Health Nurse and Advanced Practice

Nurse Committees. Collaboration among the Director of Nursing, the Regional Training Center in Atlanta, East Tennessee State University School of Nursing, and MCH resulted in the development and implementation of a course to train public health nurses to provide family planning clinical services.

Health Promotion and Nutrition/WIC: Collaborative efforts among MCH staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women started in the fall of 2001 and have included advertising the availability of the national QUITLINE sponsored by the American Legacy Foundation and other educational activities. Staff have also worked together on incorporating the "Count On Me: Heart Health is a Numbers Game" into current efforts in school health. CSS makes direct referrals to WIC on all clients under 5 or mothers of CSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for PKU children. MCH staff are working with WIC staff in assessing rates of anemia and are working to increase awareness of the effects of anemia in children and appropriate treatment.

The adolescent health director serves on the Tennessee Healthy Weight Network. This network represents a public/private partnership of over 30 state and private organizations committed to addressing the obesity epidemic within Tennessee. A press conference was organized in May 2004 to announce the official release of a state plan developed to address child/youth obesity and physical inactivity issues.

Office of Policy, Planning and Assessment: Central office staff collaborate with the Health Statistics section on dissemination of annual releases of health data and special reports, collection of data through the joint Annual Report of Hospitals, collection of data for the Region IV Data Project, and in other MCH data projects. MCH staff are coordinating with this office on implementing the newborn hearing screening data system.

Genetics and Newborn Screening: Collaborative activities for the Newborn Hearing Screening Program include participation in the Newborn Hearing Screening Task Force, the Statewide Genetics Implementation Grant Committee, the Early Hearing Screening and Detection (EHDI) CDC Grant, the Family Voices Executive Committee, the IDEA Part C State Interagency Coordinating Council (SICC), and the Tennessee Technical Assistance and Resources for Enhancing Deaf/Blind Supports (TREDS) Advisory Committee.

The Newborn Screening Program identifies infants born in the State who may be at risk for one of the disorders tested for by the State, and refers infants and families to one of the Regional Genetic Centers or Sickle Cell Centers for follow up, diagnosis and treatment. The State of Tennessee contracts with five Genetic Centers and four Sickle Cell Centers. NBS Follow-up is responsible for the follow up of infants with abnormal results on the newborn screening test. The staff work closely with local health departments across the state to assure that all infants with a possible disease are located, retested, diagnosed and treated if necessary. Children's Special Services is notified whenever an infant is confirmed with a disease.

Tennessee Adolescent Pregnancy Prevention Program: TAPPP councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent health fairs, workshops, legislative briefings, and training for professionals.

**Tertiary Care Facilities:** MCH programs that work extensively with tertiary care facilities include the perinatal regionalization system; the genetics and sickle cell centers; and the Children's Special Services Program for referrals and care coordination. These are discussed in other sections of this document.

**Federally Qualified Health Centers:** Community Health Centers are located in medically underserved areas of the state. There are twenty three Federally Qualified Health Centers (FQHC) that operate eighty nine clinic sites in Tennessee. In 2003 these community health centers provided primary health care, dental and mental health services to more than 200,000 patients. Duplication of services between the community health centers and the health departments is not a problem. In those areas where the health departments offer only traditional public health services, the community health centers are the primary care providers. Referral systems exist between those community health centers and health departments located within the same county.

**Tennessee Primary Care Association (TPCA):** Department staff work closely with the TPCA primarily through the Office of Health Access, Regional and Local Health Councils, and the Women's Health Advisory Committee.

**Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT):** Since July 2001, local health department clinics have assisted TennCare by providing EPSDT screenings to TennCare enrollees. The TennCare Program had difficulty in achieving desired EPSDT screening rates and is partnering with the Department to improve these rates. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics representatives.

**Other federal grant programs** under the administration of the Department, such as WIC, family planning, abstinence education, lead, CISS, and Newborn Hearing Screening, are discussed in other sections.

**Identification of pregnant women and infants eligible for Medicaid:** All local health department clinics provide pregnancy testing and presumptive eligibility for Medicaid. If presumed eligible, client data are entered directly into the TennCare database at the local health department site. MCH staff answer the toll-free number (Baby Line) which provides information and referrals for prenatal care. Staff at the local level work closely with the Department of Human Services on referrals for TennCare application by persons of any age. Pregnant women enrolled under presumptive eligibility are referred to DHS for further enrollment beyond the presumptive time period.

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

Data and information for the health systems capacity indicators are included on the appropriate forms as requested. Programs and activities which are addressing these indicators are discussed as follows.

**Rate of children hospitalized for asthma:** The Child and Adolescent Health Director is a member of the Pediatric Asthma Task Force for the Tennessee Chapter of the American Lung Association. Through GIS mapping, the Davidson County Public Health Department (Nashville) identified one zip code area that had a disproportionate rate of pediatric asthma compared to the rest of the city. The Task Force decided to conduct interventions in this zip code as a pilot project with the hope that successful interventions could be replicated elsewhere in the state. The overall goals of the project are to eliminate the asthma disparity, to decrease the number of emergency room visits due to asthma by 10%, and to decrease the number of deaths due to asthma. The task force has identified providers within the zip code and has provided dinner meetings for them in order to encourage use of the NHLBI guidelines. Provider packets containing the guidelines were given to them. The group also held periodic roundtables during the year for community members and gave them the opportunity to identify interventions.

The Bureau of TennCare has recognized asthma as being a high cost diagnosis through the managed care system. As a result of a TennCare Asthma Summit with representatives from all Managed Care Organizations (MCOs), recommendations were made on addressing asthma. Those recommendations were published in an Asthma Care Management Program, including quality improvement measures and provider and client educational materials. All are available to providers on-line.

Medicaid enrollees less than one year of age receiving at least one initial screen: The State's emphasis on EPSDT screening for all children is discussed in various sections of this document (State Overview, Agency Capacity, NPM #13, NPM #14, and SPM #7).

SCHIP enrollees less than one year of age receiving at least one periodic screen: The State does not designate a TennCare enrollee as SCHIP or TennCare. All are considered to be TennCare enrollees. See information above.

Prenatal visits using the Kotelchuck index: Information on the state's activities and programs addressing the needs of pregnant women is included in Agency Capacity, Other Program Activities, and NPM #8, 15, and 18.

Comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the non-Medicaid group has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. However, data over the past eight years (from the document, "Patterns of Health Services Utilizations in 2001 by Women Enrolled In TennCare", December 2002 and information from TennCare for 2002) show that the TennCare program continues to improve the health status of women in Tennessee. The overall decline in infant mortality rates in the TennCare population, in both the white and African American populations, is indicative of improved outcomes in the management and care of women of childbearing age. The percentage of low birth weight infants has remained relatively consistent from 1995 through 2002, with a slight overall increase over the time period, mirroring the total state and the nation. This data book is published annually by the Bureau of TennCare and is available on their web site. Data are included on a wide variety of women's health issues and are broken out by managed care organization and by geographic area. These data have been very helpful to the MCH section staff for monitoring and planning purposes.

Poverty level eligibility for Medicaid and for SCHIP: The state does not differentiate between the two categories. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically need eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

EPSDT eligible children ages 6 to 9 who have received any dental services during the year: Dental services for children are described in NPM #9 and in Agency Capacity. The number of children on TennCare ages 6 to 9 eligible for EPSDT services and receiving dental services increased significantly from June 2003 (54,648) to June 2004 (63,239).

SSI beneficiaries less than 16 in the state receiving services from the Children with Special Health Needs Program: All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Twenty-six percent of the 6,244 CSS enrollees have SSI. Program staff continue to contact families with newly diagnosed children and provide information on services available. Data for 2003 show that there were 18,909 SSI recipients in the state. All were contacted by CSS staff.

Ability of states to assure that the MCH program and Title V agency have access to policy and program relevant information and data: Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. These data sets include WIC, birth files, death files, linked birth-death files, hospital discharge, and the birth defects registry. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in the Bureau of Health Services and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and hearing screening are handled through the Neometrics system for MCH and the State Laboratory.

The Department of Health and University of Tennessee Medical Center are partners on a 4 year HRSA grant (April 2003 - March 2007). One of the purposes of this grant is to enhance, expand, and integrate health information systems to monitor access to care and track the health status of children identified by the newborn hearing and newborn metabolic screening programs. In 2004, a "Tennessee Child Health Profile" (TN-CHP) will be piloted from PPA servers to providers in 16 counties in and around Knoxville Tennessee. Following the year long pilot test, it is planned to expand to the other regions of the state.

Sections such as MCH do not have direct access to data, but have access through PPA or the Bureau of Health Services (HSA). The PPA staff epidemiologist assigned to MCH works with the section to provide data as necessary, to improve the quality and quantity of data sets available, and to develop the interest and commitment to address state health status issues through specific studies of data. The staff in HSA provide data and support to MCH staff for the PTBMIS data.

Tennessee does not have a PRAMS program.

Tennessee participates in the Youth Risk Behavior Surveillance System (YRBS). The survey is administered by the Department of Education every two years. The data results are available to MCH staff. The adolescent health director works closely with staff in the Department of Education on these data and programs of mutual concern. Tennessee does not administer the Middle School YRBS survey. In order to plan more effective policy and determine more effective programming for Tennessee's middle school population, data from this group are needed.

The MCH Genetics and Newborn Metabolic and Hearing Screening Programs use proprietary software from Neometrics to manage program data. The Case Management System contains data on all abnormal metabolic screening results, demographics on the infants, and information on follow-up and treatment. The system generates a letter to both the parents and the primary care provider to repeat the specimen. The system also allows tracking of each hospital's rate of unsatisfactory specimens. At this time, the data are not being linked to the birth files. On January 1, 2004, a field was added to the birth certificate for the specimen kit control number. The change is gradually being implemented across the state. It is expected that the 2005 data will be able to be linked.

The Tennessee Birth Defects Registry (TBDR) is a new system housed within PPA. In the spring of 2003, the TBDR released for the first time statewide counts of 43 major birth defects tracked by the National Birth Defects Prevention Network (NBDPN) and the Centers for Disease Control and Prevention (CDC). These data were for infants born and diagnosed in 2000. Currently, the TBDR is in the process of updating and adding to these estimates with data obtained in 2001 and 2002. The TBDR is actively collaborating with the NBDPN and the CDC to develop an effective birth defects monitoring and prevention program in Tennessee.

The following two indicators are not listed on the forms for this year; however, since the narrative for last year included this information, the two paragraphs have been updated.

Percent of adolescents in grades 9 through 12 who report using tobacco products in the past month:

This indicator is SPM #3. Data are obtained from the Youth Risk Behavior Surveillance System and available every two years. The survey is the responsibility of the Department of Education. The data results are available to MCH staff through the close working relationships of the adolescent health director in MCH and staff in the Department of Education. In addition, the Tennessee Youth Tobacco Survey provides information on use of tobacco products by youth.

Ability of states to determine the percent of children who are obese or overweight: Tennessee does not have a statewide surveillance system in place to determine the obesity rate among children and youth. Data for this indicator are very limited. MCH staff participated with the Nutrition Section and others in the development of a state plan for the prevention of obesity in children through the Tennessee Healthy Weight Network (THWN). While developing the plan, network members found sporadic pockets of child/youth obesity data which included baseline data gathered among ten Coordinated School Health Programs and within the Health Department/WIC program. Data from those programs indicate that Tennessee has a problem. Coordinated School Health data has shown a range of 19-30% of students that are overweight, and as many as 25-43% of students who are at risk of becoming overweight. A Latino Project in Memphis found that 22-34% of children were at risk of overweight or were overweight. The Tennessee Special Supplemental Nutrition Program for Women, Infants and Children up to age 5, has identified about 10% of children considered overweight and another 10% that are considered at risk of becoming overweight. In the THWN state plan, the need for the development of a state surveillance system was addressed. These data issues were identified during the recent Department of Health Lifestyle and Lifestart committees' exploration process. Final recommendations and decisions regarding this particular issue are still in development.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

The partnership between the federal government and Tennessee provides the means for improving services and activities for the MCH populations in need. The process of developing a needs assessment, planning, designing and implementing programs, and allocating resources is a critical part of the public health system in Tennessee. The Needs Assessment process has been described in previous application submissions. Section IV demonstrates progress on national and state-selected performance measures. Refer to the pyramid "Core Public Health Services Delivered by MCH Agencies" (in attached file).

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for women, infants and children. The primary emphasis of all health department activity is to assure that women, infants, and children receive the preventive care they need to reduce morbidity and mortality.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing, sexually transmitted disease screening, HIV counseling and testing, and family planning services are available in every county. All counties operate WIC and nutrition services. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child screenings in compliance with EPSDT. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental and household inspection and lead abatement activities with the families.

For children with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be retested for any one of the required metabolic diseases. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed medical and referral services.

Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and advocacy, determining presumptive eligibility for pregnant women and women with breast or cervical cancer, assistance with the appeals process, referring all CSHNC children for TennCare enrollment, and assuring that those presumptively eligible for prenatal care are receiving needed services. The care coordination component of CSS and the PEP Program provide special support and enable families to better meet their child's needs in a complex health care environment.

Population based services are available through the activities of MCH, Nutrition, Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than one-on-one contact or education. Examples include: newborn metabolic screening for all newborns; newborn hearing screening; surveillance for sexually transmitted diseases; adolescent health; childhood lead poisoning prevention program; the child fatality reviews system; SIDS counseling and autopsies; and adolescent pregnancy prevention program. Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and provide treatment. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality.

Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines. Needs assessment for health planning is a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups develop and update implementation plans and activities to address these priorities on the local level. The regional and county health councils were involved in priority setting for the MCH 2000 Needs Assessment. The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The data and systems planning functions have been greatly enhanced with the availability of SSDI funds which have been used to provide support for the statewide computer network.

Training of regional and local staff is a key role of the central office. In collaboration with Vanderbilt University's MIND (Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental Disabilities) Training Program, MCH is conducting a year-long series of interactive training on MCH programs and health issues through video-conferencing statewide. All of the regional and metro health offices have state-of-the-art video-conferencing facilities. This effort started with a plan for educating staff on the expansion of the newborn screening testing. MCH wanted to be assured that CSS and other health department staff were appropriately trained. Twelve videoconferences have been planned for the year addressing current information on specific conditions and diseases.

The identified national outcome measures have been a historic base in public health activity in Tennessee. As a Southern state, Tennessee has been concerned about and tracked neonatal, perinatal, post-neonatal and infant mortality rates for several decades. While there have been some improvements in these rates, they still lag behind the national average, the HP 2010 targets and the state's own goals.

## **B. STATE PRIORITIES**

The process used to define the MCH priority needs was described in the Needs Assessment detailed in the first year application of this five-year cycle. Six of the eight state performance measures identified for 2000-2005 have remained the same. The MCH priority needs, the national and state performance measures are closely interrelated. The needs assessment activities considered all of these in the process.

Four independent activities were completed to develop the needs assessment. These activities were: Analysis of primary health status data through the assistance of the Office of Policy, Planning and Assurance of the Department of Health.

Review of county and regional health council reports of their top health concerns and identification of those that relate to the women, infants and children population.

Review and summary of needs assessments conducted by other state organizations and advocacy groups committed to health related issues of women, children and CSHCN.

Citizen involvement through a statewide stakeholders meeting convened by the Commissioner and county health council meetings in nine counties across the state.

Health statistics data were reviewed and analyzed to determine those indicators for which the rates for Tennessee were higher than the United States as a whole. Stakeholders and county/regional health councils assisted in developing a list of five to seven health needs for each of the MCH populations (women, children, and children with special health care needs). Those needs addressed by the national performance measures were listed separately. The remaining needs became the agreed upon state needs statements. These were:

Child abuse must be prevented for child health and safety and to reduce the number of children entering state custody. (HP2010 objective 19-3 and 15-33)

Youth health risk behaviors (obesity, smoking, alcohol and drug use) must be reduced. (HP2010 objectives 19-3, 26.9, 27)

Prevent domestic violence for women and children.

Expand health education and wellness for women including pre-conceptual counseling.

Continue to emphasize prenatal care.

Prevent birth defects.

State performance measures were developed from this list of priorities. The state's identified priorities and the related outcome measures they are expected to affect are listed as follows:

Priority / Outcome Measure

Reduce preventable birth defects (focus on NTDs) / Neonatal, post-neonatal, infant and child death rates

Reduce STD rates (focus on chlamydia rates on youth and HIV infection in infants) / Perinatal mortality

Reduce child abuse and neglect / Infant and child death rate

Reduce teen tobacco use / Not related to an outcome measure

Reduce teen alcohol use / Not related to an outcome measure

Improve the state's EPSDT rates / Not related to an outcome measure

Improve the health status of women (focus on unintended pregnancy) / Perinatal mortality

Decrease elevated blood lead levels in children / Not related to an outcome measure

Priority setting is a continual process. With the current Administration in place, the Department has started a new strategic planning process. The Governor outlined his priorities for State Government. Two of these directly relate to health department activities and services. The Governor strongly believes every child deserves to grow up healthy and happy. He wants the state to work with families, agencies and foster parents to help protect children. He created a Children's Cabinet to encourage better cooperation between health agencies and nonprofit agencies responsible for children's welfare, including TennCare and the departments of Children's Services, Education, and Health. On June 14, 2004, the Governor announced the creation of a Governor's Office of Children's Care to coordinate the wide range of services and supports available to children through state departments and the private sector. The Governor has directed that the office's initial focus will be on the delivery of health care services to children. The current TennCare director has been appointed as the director of the new office.

The Governor has stated that TennCare is a fundamentally good initiative, but that it is critical to get TennCare back on track while ensuring that people who need appropriate medical coverage get it. As previously discussed, plans for reforming TennCare are in process. Two priorities address management of state government. The Governor believes that the way to avoid a budget crisis is to change the way state government works. He has been examining state government from top to bottom to find savings and identify more efficient practices. He has stated that strong management of state government begins with earning the taxpayer's trust, including establishing accountability in all state agencies.

With an April press conference, the Governor and the Commissioner of Health issued a wake-up call to all Tennesseans to start living healthier and make more responsible health choices. The goal of the "Better Health: It's About Time!" initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. The Initiative specifically targets infant mortality, prenatal care, adolescent pregnancy, cardiovascular disease, obesity, and diabetes, and also aims to eliminate racial and ethnic health disparities in these areas. The Department of Health will be working on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intragovernmental strategies to collaborate with other departments in state government. The

Department is also forming new partnerships with non-governmental agencies, community-based organizations and the faith community. The Department of Health and all sections, including maternal and child health, are involved in the development of new strategic plans for programs and activities.

The national and state performance measures and national outcome measures will be critical components of the plans.

Detailed discussion of the national and state performance measures is included in parts C and D of this section.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

The state's Genetics and Newborn Screening (NBS) Program was established in 1968 as a result of state legislation requiring PKU screening. The legislation requires that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The Genetics and Newborn Screening Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages also exist between the centers and the Children's Special Services program for referrals. An advisory committee, made up of the state's leading geneticists, guides the activities of the program and recommends changes to the Deputy State Health Officer.

The MCH NBS follow-up nurses are located in the State Laboratory to assure that all abnormal results are reported as quickly as possible. The program involves cooperation between birthing hospitals, the State Laboratory, the MCH Program staff, the Genetic Centers, Sickle Cell Centers, Pediatric Endocrinologists and primary care physicians. When an infant is identified as having a questionable specimen, the MCH NBS Program follow-up nurses contact the Primary Care Provider so that another specimen can be collected and a repeat filter paper sent to the State Laboratory or another means of confirmatory test can be done. The Genetic Centers, Pediatric Endocrinologists and Sickle Cell Centers assist in the follow-up of infants with presumptive positive results to insure rapid diagnosis and treatment. If necessary, staff in the local health departments assist in locating an infant needing follow-up.

This performance measure has been successfully met for several years due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the MCH Newborn Screening follow-up program in carrying out their duties. The State Laboratory screened infants for PKU, Galactosemia, Congenital Hypothyroidism, Congenital Adrenal Hyperplasia, Biotinidase Enzyme Deficiency and Hemoglobinopathies. There were 148 infants identified with one of the above diseases in 2001, 130 in 2002, and 125 in 2003. All were referred for appropriate follow-up.

### b. Current Activities

The State Laboratory recently leased the equipment for Tandem Mass Spectrometry testing. Testing and reporting for Maple Syrup Urine Disease, MCAD deficiency and Homocystinuria began on January 1, 2004. Newborn Screening is now testing for nine diseases, which meets the recommendations for the March of Dimes. On April 1, 2004, testing began for additional metabolites, which brings the total number to 29 types of genetic disorders. The laboratory screens 14 different metabolites on Tandem Mass Spectrometry, which in different combinations could be related to Amino Acids, Organic Acids or Fatty Acid Disorders. In July 2004, the laboratory will begin testing for additional metabolites.

The MCH Follow-up Program is providing quarterly reports to all hospitals that submit newborn screening specimens. The reports consist of the number of specimens submitted and the number of specimens that were unsatisfactory. Many of the hospitals are utilizing these reports for quality improvement and in-service training for staff that collect specimens.

Parent pamphlets have been updated to include information about Biotinidase Deficiency, Maple Syrup Urine Disease, Homocystinuria, Amino Acid Disorders, Fatty Acid Disorders and Organic Acid Disorders and have been mailed to all hospitals and health departments. Educational material has also been developed and mailed to all primary care providers statewide.

Recent efforts in this program area have concentrated on improving the program by computerizing routine procedures. A voluntary advisory committee serves to guide the program and recommend changes in tests and test procedures to the Department of Health. MCH funds have been used to support the upgrade of hardware and software for this program to accommodate the new tests.

#### c. Plan for the Coming Year

All previously described testing and follow-up services will continue. The Genetics Advisory Committee will be exploring testing for cystic fibrosis and assisting the MCH and Laboratory staff in re-evaluating the cut-off values to decrease the number of false positive rates. Staff will continue to monitor the needs for upgrading computer hardware and software and improving efficiency through the use of computerization.

*Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### a. Last Year's Accomplishments

CSS has continued developing relationships with parent groups in order to better facilitate the needs of the entire family. CSS engages parents at all levels of the program including a parent of a CSHCN serving on the CSS Advisory Board. CSS also has continued to employ parent consultants through the Parents Encouraging Parents (PEP) component of the program. These parents are part of program staff and participate in programmatic planning and decision making and serve as a liaison between program and clinic staff and the parents. Each regional CSS office conducts parent satisfaction surveys at least once a year and makes changes based upon the results of these surveys.

#### b. Current Activities

CSS is currently in the process of contracting out to a private provider those services covered under the (PEP) Parents Encouraging Parents component of CSS. All parents currently employed by the state PEP program will continue to be employed and will serve as parent consultants to CSS, as well as provide support duties.

CSS staff collaborates with groups who are advocates for children with special health care needs. The Governor's Children's Cabinet, Family Voices, and Child Health Policymakers are just a few of the CSS partners. This partnership includes regularly scheduled meetings as well as participation in the CSS annual meeting to discuss CSHCN needs in accessing services, prioritizing needs, and presenting them to policymakers to help determine legislative action. Priorities identified at this year's meeting included cultural competence, systems of care,

transitions to adulthood, and the re-design of the CSS Family Service Plan.

For each child enrolled in CSS, program staff, along with each child's family develops a Family Service Plan (FSP). The FSP is an assessment tool from which a problems/needs list is developed. The assessment tool includes family medical and non-medical needs such as educational needs of other family members, counseling needs, transportation, food, clothing, shelter, and employment needs. The FSP is shared with the child's primary care provider (PCP) and other agencies working with the child for coordination of care. Similarly, the Department of Education's Early Intervention Program (Part C) develops an Individualized Family Service Plan (IFSP) and Part B develops an Individualized Education Plan (IEP) which is shared with CSS and becomes part of the child's CSS record if health care needs are addressed. CSS refers to and coordinates payment for medically necessary services with other agencies.

#### c. Plan for the Coming Year

CSS will ask for an additional parent to serve on the CSS Advisory Board. CSS staff will continue to work with local and statewide groups on behalf of children with special health care needs and will continue to conduct surveys in order to ensure all needs of the child and family are met. Staff will continue to utilize the Family Service Plan, the IFSP and the IEP when planning for the needs of the child and family.

*Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### a. Last Year's Accomplishments

Tennessee has defined medical home as the health care provider or primary care physician (PCP) selected by the family or assigned by the child's TennCare Managed Care Organization (MCO) or insurance company. If a CSS enrolled child does not have a PCP, the CSS program will assist the family in identifying a pediatrician, family practitioner, or specialist to serve as their medical home. All CSS enrolled children are considered to have a medical home with care being coordinated, ongoing, and comprehensive. The CSS Family Service Plan (FSP) is initially developed on admission to the CSS program and is reviewed at six month or annual intervals and includes an assessment of well child visits and immunizations. CSS recognizes the flexibility of states in designing and implementing their Title V programs and works with CSHCN moving to Tennessee from other states or moving from Tennessee to help transition these children to a medical home. These activities reduce confusion and insure the continuity of Title V services for these children.

CSS central office staff have worked closely with the PTBMIS staff in the Bureau office to develop an automated system for standardized reporting for the CSS program. Program data are entered into the PTBMIS computer system by CSS staff across the state on all CSS children. The reports have been formatted into a system called "CUBES" which is being used for routine retrieval of program data at the central office, regional, and local levels. The reports for monitoring all CSS activities have been fully implemented. These reports help identify a child's medical home as well as those children who do not have one identified. CSS Care Coordinators continue to work closely with PCPs in helping identify those medical needs not associated with the child's diagnosis and the resources available. Referrals to the appropriate provider are then obtained.

#### b. Current Activities

CSS continues to be pro-active for ensuring all children with special health care needs are

receiving coordinated, ongoing, comprehensive care within a medical home. Care Coordinators remain the consistent link between the family, the PCP, and other providers. Available data reports are being used to monitor activities across the state.

### c. Plan for the Coming Year

All program activities described in the above sections will continue. Program staff will continue efforts to further educate local primary care providers on the medical home concept and the services provided by the CSS program, work closely with the providers on coordination efforts and strengthening referral patterns. All program policies have been re-evaluated for addressing coordinated, ongoing, comprehensive care within a medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

### a. Last Year's Accomplishments

The CSS program has always provided medical and specialty services for enrolled children. The program has a policy that all children must apply for TennCare before acceptance to CSS. TennCare is Tennessee's Medicaid program but also covers uninsured individuals. As a TennCare member children are assigned a primary care provider (PCP) by their managed care organization (MCO) and receive many of the medically necessary services once paid for only by CSS. CSS works in collaboration with the managed care system to accommodate the strengths and limitations of this managed care child health infrastructure by having different financial eligibility criteria, by serving different populations and by funding different sets of medical and related services. The program provides services for those children whose needs have been denied and upheld through the appeals process by the MCO and the Bureau of TennCare.

The CSS program established a statewide care coordination program in 1990 open to children with special needs enrolled in the CSS program. In 1997, care coordination was expanded to serve special needs children not diagnostically or financially eligible for the medical service component. These services are available to other special needs children not enrolled in TennCare. Care coordinators are assigned to every county in the state; the typical caseload is 80--120 children. Care coordinators work to assure that families are aware of and access services they need including educational and social services. Annual home visits are conducted and care coordinators are frequently involved in the Individualized Education/Family Service Plan (IEP/IFSP) meeting used to establish an agreed upon plan to address the child's needs. Families are also linked with the Parents Encouraging Parents (PEP) Program.

CSS staff have worked closely with MCOs and other insurance companies this past year to ensure all service needs of the child are being met. CSS continues working with the MCOs in developing a list of direct contacts of those staff who have knowledge of the mission and services of the CSS program. CSS has ensured that the provision of medically necessary services is coordinated with the medical home and other providers and coordinates payment sources such as private insurance, TennCare, Head Start, and the Department of Education to prevent the duplication of services and ensure continuity of care when the transition to public school services occurs.

### b. Current Activities

All services described in the above section continue. The CSS Program Director continues to meet with key personnel from TennCare for coordination benefits of services provided. CSS

staff at the regional and local levels contact the Nurse Case Managers with the managed care organizations to ensure that all service needs of the child are being met. Ninety-three percent of all children on CSS receiving medical services have some form of medical coverage which will cover the CSS approved diagnosis. Over 600 appeals were filed by CSS on behalf of the child for obtaining denied or delayed needed services. This number of appeals is approximately 50 percent fewer than the previous year due to closely linkages and negotiations for services which are occurring on the front end rather than through the appeal process.

**c. Plan for the Coming Year**

All services described above will continue. The Program Director will receive an updated list identifying contacts within each MCO as well as other insurance providers. The contact list will be distributed to appropriate field staff that will continue negotiating services with other providers and will file an appeal when necessary.

*Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

**a. Last Year's Accomplishments**

CSS has been a leader for integrating health services for CSHCNs with other health department programs including; well child exams, immunizations, Women, Infant, and Children (WIC), as well as other state agencies such as Department of Mental Health/Developmental Disabilities, the Department of Mental Retardation Services, the Department of Education, local mental health centers, and local school systems to develop a system of care approach. Inter-agency team meetings are held to review and coordinate family-centered plans of care.

**b. Current Activities**

CSS continues to identify needed services which are community-based and easily accessible. Staff works closely with MCOs, insurance companies, and other providers for improving access to local services. Patient satisfaction surveys are conducted annually during regular clinic visits.

**c. Plan for the Coming Year**

CSS will continue to assess the availability of local resources for being easily obtained. Staff will continue working with MCOs, private insurance, and other providers for identifying local resources found within the community. A parent satisfaction survey will be distributed to parents of children on the program which will assess the ease of services.

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

**a. Last Year's Accomplishments**

The CSS Family Service Plan has been updated to include assessment and evaluation of services related to children who are 14 years of age and older and are in need of transition to adulthood. The statewide annual CSS staff meeting was held in March 2004. The theme of this year's meeting was "Transition to Adult Services." Most of the sessions included staff training on transition. The Family Service Plan was revised to include a specific transition assessment. Other new tools for care coordination included a transition checklist for parents to use and a pocket size health passport. In-depth transitional training for staff was provided by the Kentucky

Healthy and Ready to Work Program. Program staff have identified and collaborated with those resources in the community which can best meet the needs of all aspects for transitioning to adult life.

#### b. Current Activities

All the above activities are being continued, and resource information is updated on a regular basis.

#### c. Plan for the Coming Year

CSS will continue to receive updated training on transitions to adulthood for all aspects of life. Program staff will continue to work with communities and agencies to ensure there are available resources that meet the needs of the CSS enrollee during this transition.

*Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### a. Last Year's Accomplishments

The Tennessee Immunization Program (TIP) is administered by the state's Communicable and Environmental Disease Services Section within the Department of Health. The TIP's goal is to reduce or eliminate the occurrence of vaccine preventable diseases through the immunization of susceptible persons and the investigation of outbreaks. The TIP's main functions include, but are not limited to the following: (1) acquiring vaccine for use in public clinics and private physicians offices who are enrolled in the Vaccines for Children (VFC) Program, (2) assessing immunization coverage levels in the state population as a whole and among certain population sub groups, (3) devising and setting policy which will result in increasing immunization level coverage, (4) investigating and controlling the occurrence of cases of vaccine preventable diseases, and (5) insuring that the public is aware of the importance of age-appropriate immunizations and immunization requirements.

The TIP has invested a lot of time and energy in developing a web site for use by private physicians. This has become a necessity as more and more children are being seen in "medical homes" outside the health department. Fully 70% of children now receive all their immunizations at private physician's offices. The TIP has also held training sessions for those physicians enrolled in the VFC program in order to keep them informed regarding the program's varied requirements. The TIP has also been more involved in service delivery assessment in private physician's offices in an attempt to assure the proper adherence to VFC requirements and the proper storage and handling of VFC purchased vaccines in the enrolled practices. Insuring the adequate immunization of patients at risk of not completing their immunization schedules has been another quality assurance activity of the program.

Data from the assessment of 24-month old children infer that children with 2 or more siblings, children who start immunizations at >120 days of life and children on TennCare who receive all their immunizations at private offices are at increased risk of not completing immunizations. These children are followed to insure they do complete immunizations on time. Also of special interest are children born to women who are hepatitis B surface antigen positive. These infants and their household contacts are followed to ensure that they receive prophylaxis for hepatitis B and a confirmatory post vaccination serology.

Data from the survey of 24-month old children for previous years was based on the level of completion as 4 DTaP/3 polio/ 1 MMR and show percentages for the past four years ranging

from 85.6 to 88.2. Data for 2003 provided on form 11 are based on immunizations for all the diseases listed, and the percentage was 78.4. For comparison purposes, 2003 data using the previous year's schedule was 83.7 percent.

#### b. Current Activities

The Immunization Program now focuses on the following strategies to increase age-appropriate immunization levels among the state's citizens:

- (1) Assessing the immunization status of (a) children 24 months of age, (b) day care attendees, and (c) kindergarten and seventh grade school students;
- (2) Increasing adult immunization levels by (a) increasing opportunities to immunize adults for whom influenza vaccine is recommended, (b) ensuring compliance with institutional requirements (such as occupational and educational mandates) for adults, and (c) focusing on immunization of adults with high risk behaviors (such as immunizing STD patients with hepatitis B vaccine);
- (3) Performing Vaccines for Children (VFC) quality assurance visits and Assessment, Feedback, Incentive and Exchange (AFIX) assessments in public clinic and private provider's offices;
- (4) Insuring that children at high risk of not completing their series of immunizations by the recommended time receive special attention and assistance in completing their immunization schedules, especially children born to women who are hepatitis B surface antigen positive;
- (5) Increasing the participation by private physicians in the state's immunization registry; and
- (6) Collaborating with professional organizations and other governmental agencies, such as the Tennessee Chapters of the AAP and AAFP, the Tennessee Hospital Association, and the Tennessee Departments of Education and Human Services; to promote the goals of the Immunization program.

#### c. Plan for the Coming Year

The strategy will be much the same as this year. The major new objective will be to maintain or improve the quality of the service delivery of immunizations both in public clinics and private practice through the aforementioned steps and increase the amount of private physician-administered vaccine doses that are reported to the immunization registry. The eventual goal will be to employ the registry as the means of evaluating the entire program.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### a. Last Year's Accomplishments

Calendar year 2003 data from the Family Planning Annual Report show that the program served 39,654 clients ages 19 and under -- an increase of 1.5 percent over calendar year 2002. The state is providing EPSDT visits for children and adolescents in the local health departments, under contract with TennCare. During FY 2003, the health department clinics performed 51,845 screenings, of which 5,025 were to adolescents ages 12-17. These exams include assessment regarding sexual activity and referral for family planning services when needed.

The Nashville Adolescent Pregnancy and Prevention Council, in conjunction with the state's Title X program, sponsored "Children of Children: Portraits and Stories of Teenage Parents", a traveling multi-media exhibition by photographer Michael Nye. Approximately 30,000 persons viewed the exhibit during its two-month run.

The Director of Adolescent Health conducted developmental assets training for educators, abstinence education conference attendees, nonprofit youth staff, coordinated health pilot sites

staff, and health educators staff.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community. Each council participates in a wide range of activities, depending on local priorities and resources. Providing community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, and through health fairs, media presentations, and loans of films and materials is a TAPPP priority. In CY 2003, the Family Planning program and TAPPP provided community family life education programs to approximately 85,000 students, 18,000 adults, and 6,000 professionals. For example: The two Nashville area TAPPP Coordinators arranged to have two days of "Adolescent Health for Youth-Serving Community Based Agencies" training conducted for 73 participants, representing 41 Nashville and mid-state agencies.

The Department contracts with United Neighborhood Health Services (UNHS), a Nashville-based health care group, to staff a toll-free information line specifically for teens. Four staff members who regularly provide prevention and intervention services staff the line from 8:30am to 5:00pm Monday through Friday.

#### b. Current Activities

During the first six months of FY 2004, 15,013 adolescent clients age 19 and under were provided services through the statewide Family Planning Program. Educational services have been provided to 2,751 parents, 22,309 adolescents and children and 8,921 adults, and consultation, training, or technical assistance provided to 5,162 professionals. Assistance in teaching abstinence and sexuality education curricula, health department services, and community awareness of teen pregnancy and parenting issues were among the topics addressed.

The Abstinence Only Education Program funds 22 community-based projects across the state, serving approximately 39,000 youth. The program also provides educational resources to the public and holds an annual fall conference for youth-serving professionals. The Community Prevention Initiative currently funds 70 programs in 51 counties, targeting children 0-12 who are at high risk for becoming involved in self-destructive behaviors.

Eleven regional and metropolitan county nurses attended an Adolescent Health Care conference in Boston, Massachusetts, on May 6-8, 2004. The conference focus was on practical approaches to prevention, diagnosis and management of common adolescent health problems, and strategies for working with teens and their parents to modify risk-taking behavior. The participating nurses are expected to serve as the liaison with central office for adolescent health issues and as the primary contact for adolescent health issues in their own health departments.

In February 2004, the Director of Adolescent Health applied to the Association of Maternal and Child Health Programs (AMCHP) and the State Adolescent Health Coordinators Network (SAHCN) to be considered for participation in an adolescent health systems capacity assessment tool pilot project. Tennessee was one of three states selected for the project (Wisconsin and Utah were the other two states). In May 2004, three consultants from AMCHP and SAHCN led a team of 14 people from within the Tennessee Department of Health through a two day session where the tool was applied to assess Tennessee's systems capacity level to address adolescent health issues. Feedback from the two day process was collected so that the tool could be refined to better meet the needs of state adolescent health personnel throughout the U.S. A final systems capacity assessment report will be provided to Tennessee

staff by fall 2004.

### c. Plan for the Coming Year

MCH programs will continue to offer clinical and educational services to the adolescent population and offer support, technical assistance, and training to community agencies and other groups working towards lowering the teen pregnancy and birth rates.

In April 2004, the Tennessee Department of Health launched a new long-term initiative called "Better Health: It's About Time!". The initiative has two components: "LifeStart", which specifically targets adolescent pregnancy, infant mortality, and prenatal care; and "LifeStyle", which focuses on cardiovascular disease, obesity, and diabetes. The initiative seeks to eliminate racial and ethnic health disparities in these areas.

The state's teen birth rate has been declining over the last decade, and projections indicate that this trend will continue. The availability of reproductive health services, health education, and community support for the prevention of teen pregnancy have all contributed to this improvement. Programs such as the Tennessee Adolescent Pregnancy Prevention Program, the Family Planning Program, the Abstinence Education Program, the Community Prevention Initiative Projects, and youth development and assets building training have provided leadership towards lowering the teen birth rate and achieving this objective. Adolescent pregnancy (ages 10-17) data for 2002 show the lowest rate recorded since 1975. In 2002, the pregnancy rate for this age group was 14.1. The rate dropped for both the white and the black populations; however, the gap between the two groups remains. For 2002, the rate for the black adolescent population was 2.3 times that for the white population. Pregnancies in the 15-17 age group also declined, from a rate of 37.3 in 2001 to 35.6 in 2002. In 2002, there were 4,075 pregnancies to this age group, with 3,225 actual births (15 = 443; 16 = 1,023; 17 = 1,759). As in the larger adolescent group, this sub-group shows a substantial gap between the black and white populations. The baseline rate for births to adolescents ages 15-17 was 42.5/1,000 in 1995. By 1998, the rate had fallen to 38.1/1,000. The age-specific fertility rate for adolescents age 15-17 in calendar year 2002 was 28.2. This continues the decreasing rate for this population.

*Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

### a. Last Year's Accomplishments

Dental data on the population of third grade children with existing sealants on at least one molar was almost 10%. These data were tabulated from exams conducted during the School Based Dental Prevention Program. These "target" schools are those with more than 50% free and reduced lunch. The source of this information is therefore not a random sampling. The data on the School Based Dental Prevention Program show the number of children receiving preventive sealants in Tennessee is increasing annually. The state has placed a great deal of emphasis and implemented programs actively related to improving the oral health status and access to dental care for children.

Dental services are required under EPSDT guidelines that are to be followed by the managed care organizations (MCO) under contract with TennCare. However, there have consistently been significant shortages of dentists in MCO networks, and some areas of the state have had no dental services available. Efforts were begun by the Department in the spring of 2001 to improve access to dental services for low-income Tennessee children and have continued. Over this last fiscal year, the Department of Health (TDH) has continued to expand its dental program. Specifically, clinical dental programs were enhanced through one-time special needs

grants; preventive dental services are now provided statewide through a contract with TennCare which funds the School Based Dental Program; and three mobile dental clinics are providing comprehensive dental services to children in remote underserved areas. Dental special needs grants were awarded to 22 counties. These one-time funds were used for renovation or upgrading existing dental facilities and for new dental construction. Projects have been completed in 16 of the 22 counties.

School based dental prevention services are being delivered in all 13 regions. Data for FY 2003 show that dental screenings were conducted in 297 schools; 102,753 children had dental screening. Of these, 30,690 children were referred for care. Periodic oral evaluations were conducted on 35,466 children. Dental sealants were done on 215,775 teeth (40,788 children). Oral health education conducted in the classrooms by dental hygienists is considered to be a standard procedure in the school-based dental public health programs; for FY 2003, a total of 127,111 children were provided oral health education. Dental outreach activities include provision of informational material for TennCare enrollment purposes and follow-up contacts for TennCare recipients identified as having unmet dental needs who are experiencing difficulty accessing dental care.

Three mobile dental clinics purchased by the Department operated in three rural regions in an effort to provide access to dental services for high risk children in underserved areas. In 2003, 11 school sites were visited by the mobile dental clinics. 264 patients were treated and 1886 dental services provided with a value of \$115,151.

## b. Current Activities

All dental activities, both clinical and educational, continued into the current year. For FY 2004, dental screenings were conducted in 328 schools and over 200 non-school sites. At these locations July 1, 2003-May 31, 2004, 138,489 children had a dental screening. Of these, 41,435 children were referred for treatment. Periodic oral evaluations were conducted on 66,213 children (35,265 with TennCare). Dental sealants were done on 283,507 teeth (46,510 children). Oral health education conducted in the classrooms by dental hygienists is considered to be a standard procedure in the school-based dental public health programs; for FY 2004, a total of 154,686 children were provided oral health education. Dental outreach activities continue. Currently, 60 out of 95 counties have dental clinics.

For FY 2004, the three mobile dental clinics provided care to more than 600 children with a value of over \$332,400.

The mobile unit in Mid Cumberland has also been exhibited (along with educational activities) at statewide professional meetings and was at the All About Women show held in August 2003 in Nashville for an audience of 15,000 women; it will again be a part of the August 2004 show.

During this year's legislative session, the Dental Practice Act was amended by adding the following language as a new appropriately numbered subsection: "The application of fluoride varnish to the teeth of at risk, underserved persons in or under the auspices of a state, county or municipal public health clinic by public health nurses or nurse practitioners." This legislation allows public health nurses to apply a low-cost, effective fluoride varnish on the teeth of at risk, underserved children. The program is being implemented through training sessions which are beginning in June for all public health regions. The intent of training is to "train the trainer". A training manual has been developed which will be provided to each Public Health Clinic and Dental Director. The training manual consists of: acknowledgments, mission statement, preface, program overview, fluoride varnish protocol, the training session, sample forms (consent and information for parents), and additional resources.

The program is based on the need to prevent early childhood caries (ECC), once referred to as

baby bottle tooth decay (BBTD). The change in title is based on the fact that there is a broader range of risk factors for ECC than just the baby bottle. Renaming the condition allowed for more thorough and better recognition of causes.

### c. Plan for the Coming Year

All dental activities, clinical and educational, will continue to be available across the state.

The new fluoride varnish program will be implemented during the next year. In addition to initial training sessions, central and regional office dental staff (dentists and dental hygienists) will be providing any additional support and technical assistance as needed. It is being suggested that the fluoride varnish applications be a part of the EPSDT screenings. Central office staff will be adding new sections to the implementation/training manual; a section on anticipatory guidance will be developed as the next component.

*Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

### a. Last Year's Accomplishments

The state's rate of death from motor vehicle crashes for children ages 14 and younger has been on the decline since 1990. The rate of death for this age group in 2002 was higher than the 2000 and 2001 rates, but lower than the 1999 rate. The overall rate for the past 12 years has declined from a rate of 8.2 per 100,000 children in 1990 to a rate of 5.3 in 2002. Provisional data for 2003 for this age group shows a rate of 4.0 per 100,000 children.

There continues to be a disparity in the rate of deaths to children of this age group in the African American population. While the rate for both African American and white children has declined, the mortality rate for African American children continues to be higher with a rate of 5.8 per 100,000 children in 2002 as opposed to a rate of 5.0 per 100,000 white children.

In 2003 the General Assembly enacted Tennessee Code Annotated 55-9-602 which states that infants under age 1 or children weighing 20 pounds or less must ride in a rear-facing child safety seat in the back seat of the vehicle. It further requires that children age 1 through 3 and weighing more than 20 pounds must ride in a forward-facing child safety seat in the back seat of the vehicle. Children ages 4 through 8 and measuring less than 5 feet tall must ride in a belt-positioning booster seat in the back seat of the vehicle. This requires the use of both a lap and a shoulder belt. Children ages 9 through 12 and measuring 5 feet or more in height must buckle up and should ride in the back seat of the vehicle. Children ages 13-15 must buckle up. Violation of this law is a primary offense and a \$50 fine can be levied. This law goes into effect on July 1, 2004. This law also established, within the general fund, a revolving special account known as the Child Safety Fund. The law also established that the Department of Health will coordinate the quarterly distribution of money in the fund to health care institutions within the state.

Each year, the State Child Fatality Review Committee reviews recommendations by local child fatality review teams and submits recommendations to legislators, the Commissioner of Health and other programs within the Department of Health through the publication of an annual report.

### b. Current Activities

Collaboration has continued with the Safe Kids Coalition in identifying prevention strategies as well as to provide support to public awareness campaigns provided by their coalitions. Efforts

are continuing to develop new and enforce current legislation that ensures proper regulations for hauling objects in open vehicles on any roadway and studying the feasibility of a law that prohibits children less than 13 years of age from riding 4-wheeler type vehicles. Health educators across the state have continued to conduct injury control activities on seat belt and child safety seat usage. These activities primarily focus on seat belt surveys and child safety seat checks and include collaboration with local law enforcement, fire departments, car dealerships and other community groups. Training has continued for hospital nurses on car seat basics and evaluation of transportation systems for some Head Start Centers. The Health Promotion Division of the Department of Health has developed rules and regulations related to the distribution of the revenue from the child safety fund. Anyone utilizing these dollars will have to follow the rules and regulations related to child safety seats.

#### c. Plan for the Coming Year

Efforts will continue to educate both health department staff and the general public about the child safety seat law. The collaboration with Safe Kids Coalition will also continue. Local health educators will continue to utilize epidemiological data to identify target counties and populations, and organize or participate in many of the activities from the current year. Each health educator submits an annual plan to the Health Promotion Division outlining activities that will be done in the coming year. All focus areas are determined based on a data assessment indicating the health promotion priority of the local health educator. Home visiting staff will also receive training on the child safety seat law. They will in turn provide education to pregnant women and parents of young children on the appropriate use of child safety seats. The rules and regulations related to distribution of funds from the Child Safety Fund will be implemented this year.

### Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

Data on breastfeeding rates at hospital discharge are obtained from the Ross Mothers' Survey, an ongoing mail survey that has been conducted for many years. Data for 2002 for Tennessee indicate that the breastfeeding rate for all infants was 61.4%. This compares to 41.6% in 1990, 50.6% in 1995, and 59.2% in 2001.

Breastfeeding is widely promoted through the statewide WIC program and by other local health department staff providing services to pregnant women. All rural and metropolitan regions have breastfeeding coordinators who work with staff, clients and providers in the community. Each local health department has a breastfeeding advocate who provides services to clients. Young mothers are encouraged to breastfeed; literature is provided before delivery; and a counselor is in contact with the mother to support her efforts after delivery. Each of the 19 nutrition centers established through the WIC program statewide has a room exclusively used for breastfeeding mothers. These centers have a vital role in the community as a location for classes on a variety of topics including the promotion of breastfeeding. Other health departments have set aside space for use by breastfeeding mothers.

The Baby Friendly Hospital Initiative is a global program sponsored by the World Health Organization and UNICEF to encourage breastfeeding by recognizing hospitals and birthing centers that offer an optimal level of care for mothers who breastfeed. Using the 10 steps as a model, the state of Tennessee created the "Baby Friendly Health Department" Initiative to recognize health departments that exceed the minimum requirements to support and promote breastfeeding. To be recognized as "Baby Friendly", the health department must provide documentation that all 10 steps of the plan are complete. As of September 2003, fifteen health

departments have received a "Baby Friendly Health Department" certificate of recognition for breastfeeding support.

According to a 2001 Breastfeeding Telephone Survey conducted by Edge Healthcare Research, one-third of the women enrolled in the Tennessee WIC Program work outside the home and 22% of the breastfeeding women interviewed declare "went back to work or school" as the reason why they stopped breastfeeding. In an effort to increase breastfeeding duration, the WIC Program purchased "mini-electric" pumps for breastfeeding moms returning to work. It is anticipated that the issuance of a personal electric pump will enable more mothers to breastfeed longer, in line with the American Academy of Pediatrics recommendation that mothers breastfeed for at least a year, and for as long thereafter as mutually desired.

The breastfeeding rate for WIC mothers held steady at 29%.

#### b. Current Activities

All breastfeeding activities as previously described continue across the state. Currently, there are two new nutrition centers under construction; these will have a separate room for use by breastfeeding mothers.

Tennessee has been awarded a special \$74,999 grant from USDA to promote breastfeeding using social marketing principles. The official name of the grant is "Using Loving Support to Build a Breastfeeding Friendly Community". The goal of the project is to raise public awareness, acceptance and support of breastfeeding. The grant targets rural West Tennessee, the region of the state with the lowest breastfeeding rates. A comprehensive plan developed by WIC staff and community partners to address specific barriers in West Tennessee will serve as a model for the rest of the state.

#### c. Plan for the Coming Year

USDA awarded an infrastructure grant to Tennessee in 1999 to implement a new technology to collect and analyze comprehensive data from pregnant women and breastfeeding mothers. The purpose of this intensive data collection effort was to determine strategies that are successful in increasing both the number of women who breastfeed and the length of time they breastfeed. Surveys were written to identify these factors which encourage or discourage breastfeeding and programmed into handheld computers, also known as Personal Digital Assistants (PDAs). PDAs were purchased for breastfeeding counselors and nutritionists to gather information in any setting. The data being collected include information on the client's knowledge of breastfeeding benefits, plans to return to work or school, smoking status, any history of breast surgery, family support of breastfeeding, hospital experience, use of hormonal contraceptives after delivery, introduction of solid food, primary reason for breastfeeding and reasons for weaning. Data are being collected during routine visits at the local health department, telephone consultations, and home or hospital visits. The data compiled over the past three years will be evaluated in the fall to determine strategies to increase breastfeeding rates in WIC participants. The evaluation process will begin with measuring whether or not incidence and length of breastfeeding has increased among our WIC population. In instances where these measurable outcomes improve, the data will be analyzed to determine if influences such as personal contacts were increased or if there was a support person in the home.

All previously described activities to promote breastfeeding will continue.

#### **a. Last Year's Accomplishments**

In 2003, an estimated 97% of Tennessee infants were born in a hospital with access to hearing screening. Calendar year 2003 data indicated 86 of the total 89 birthing facilities provided hearing screening prior to hospital discharge. There were 84,015 births (resident and non-resident) (provisional data per vital records) in 2003. There was no mandate to provide hearing screening in Tennessee, nor was there a requirement to report hearing screening results to the state in 2003. Sixty-six (66) of the hearing screening hospitals voluntarily reported hearing screening results on 53% (44,155) of all infants. Results were reported on the Newborn Screening genetic/metabolic blood-spot form. Of the 44,155 hearing results reported, 2.9% (1218) were referred for further testing and 63% (796) received follow-up. Eight infants were confirmed with hearing loss. Activities for data collection, program monitoring and evaluation continue with NHS, EHDI, and the TN Department of Education's IDEA Part C Child Find and Early Intervention System (TEIS). A data system to capture follow-up and tracking activities completed by TEIS was implemented July 1, 2003. The follow-up rate greatly increased to 93% in the first three months after TEIS staff began to contact parents and primary care providers to obtain follow-up test results and/or to assist families to obtain a hearing evaluation. Documented follow-up rates increased from 24.4% (CY2002), to 42% (Jan.-Jun, 2003), to 93% (July-Sept. 2003) for an average follow-up rate of 63% for CY2003.

Educational activities included two regional trainings conducted in September 2003 on "Newborn Hearing -- After the Screen". Christie Yoshinaga-Itano, Ph.D, University of Colorado was the guest speaker. The audience included 230 participants (audiologists, physicians, medical residents, nurses, speech/language participants, early intervention (EI) staff, CSS staff, adults and families with hearing loss. Other educational activities included site visits to hospitals, training for EI program staff, medical residents, neonatal nurses, physicians groups, and support organizations. More information about the state's hearing screening program is available on web site of the National Center for Hearing Assessment and Management (NCHAM) (Individual State Profiles) at [www.infanthearing.org](http://www.infanthearing.org) and at the Centers for Disease Control and Prevention Early Hearing Detection and Intervention (EHDI) ([www.cdc.gov](http://www.cdc.gov)).

#### **b. Current Activities**

All screening activities continue.

Follow-up rates are expected to increase due to a revision in the Genetic/Metabolic Newborn Screening Rules and Regulation that became effective January 28, 2004. The revision requires hospitals to report hearing screening results on the blood spot form and defines the role of the Department of Education's Tennessee Early Intervention System (TEIS), Part C, Child Find to conduct follow-up activities for infants referred for hearing screening. In February 2004, Newborn Hearing Task Force members attended the National Early Hearing Detection and Intervention (EHDI) conference sponsored by CDC and HRSA. Attendees included CDC EHDI grant staff, the NHS Program Coordinator, NHS Parent Consultant, the NHS Audiology Consultant, a parent of a toddler with hearing loss, the AAP Tennessee Chapter Champion, a Tennessee Infant Parent Services (TIPS) representative and an IDEA, Part C, TEIS early intervention representative.

A NHS Task Force sub-committee is currently developing Tennessee Guidelines for Audiologic Assessment and Amplification. The new guidelines are to be presented at the October 2004 Tennessee Association of Audiologists and Speech/Language Pathologists (TAASLP) and the Tennessee Chapter of the Academy of Audiologist (TAA) annual conference. Two posters promoting hearing screening are ready for distribution to primary care providers statewide. Web pages are being developed for the Tennessee Newborn Hearing program in conjunction with the Newborn Screening program.

### c. Plan for the Coming Year

All screening activities will continue.

A statewide training on Audiologic Assessment and Amplification is scheduled for December 2004. The target audience will be audiologists, medical specialists, primary care providers, parents/consumers, and early intervention providers. Educational packets for families of children with a confirmed hearing loss should be ready for distribution by Fall 2004. The NHS program will work closely with hospitals to implement the reporting of hearing screening results on the Newborn Screening blood-spot form. There are plans to provide funding for hearing screening equipment to several very small birthing/midwifery centers and to extend use of hearing screening equipment for the home birth population. The intent is to provide access to hearing screening by 100% of the birth population.

## Performance Measure 13: *Percent of children without health insurance.*

### a. Last Year's Accomplishments

Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census, 2003 Annual Social and Economic Supplement, CPS data show that 89.2% of all persons and 93.2 percent of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2000-2002 show that 4.3% of the 63,000 children under age 19 and at or below 200 percent of poverty were without health insurance in the state. Data from the Children's Defense Fund show that 7.5% of children under age 19 were without health insurance in 2002, with a three-year average for 2000-2002 of 7.0%.

The state's managed care program for Medicaid recipients and the uninsured remains the major focus on providing health insurance coverage for children. In 2003, 786,407 children ages 0-21 years were enrolled in TennCare statewide. Of these, 5.8 percent were under one year of age and 19.6 percent were ages 6-9.

The Department has negotiated agreements with all of the MCOs operating in the rural regions to provide some traditional public health services without prior authorization. The Bureau also had agreements in 2003 with selected MCOs to provide gatekeeping primary care services in fifteen rural counties. Effective July 2001, TennCare requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to TennCare enrollees. Federal law requires all under 21 Medicaid recipients to have access to these services. The State had encountered difficulties in providing EPSDT. During state fiscal year 2002, health department clinics provided 43,512 EPSDT screening. During state fiscal year 2003, these clinics provided 51,845 EPSDT screenings.

All local health departments offer pregnancy testing and if pregnant, screen for income and enroll the women into TennCare under presumptive eligibility. Pregnant women are eligible for TennCare if under 185 percent of the federal poverty level. The information is entered into the TennCare data base directly by health department staff so that the women are immediately on TennCare and eligible for coverage of needed services.

All children enrolled in the Children's Special Services program are required to apply for enrollment in TennCare. Ninety-three percent of the children receiving medical services are on TennCare. Each child is assigned to a care coordinator who assists the family in accessing needed medical services, including preventive, routine medical care, and specialty care. The care coordinator also assists the family with the TennCare appeals process, as needed.

All health department clinics provide advocacy and outreach for TennCare, and through contact with low income persons and families receiving a wide variety of services (home visiting, family planning, immunizations, etc.) make referrals to DHS for potential enrollment into TennCare.

#### b. Current Activities

June 2004 TennCare data show that there are 782,057 children ages 0-21 years on TennCare. Of these, 5.9 percent are less than age one, and 18.5 percent are ages 6-9. All local health department activities described in the report of last year's accomplishments continue. Referrals are made to the Department of Human Services (DHS) for TennCare enrollment of any families with children who may qualify. All local health department clinics provide presumptive eligibility for pregnant women to enroll in TennCare and referral to DHS for enrollment; this service not only assists with entry into prenatal care, it provides for enrollment of the infant at birth. All health department clinics provide EPSDT screening exams for children. For this fiscal year, it is estimated that the annual number of screens will increase to over 60,000. The West Tennessee counties are providing the largest numbers of screens; these geographic areas contain large numbers of children on TennCare.

Currently, eleven of the rural counties are gatekeeper counties and have been assigned 13,600 TennCare clients by the managed care organizations. These enrollees include persons of all ages. This is a reduction from last year's number of counties serving as gatekeeping counties due to changes in the managed care organizations providing TennCare services in one specific region.

The local health departments play a major role in assurance of access to needed services through approved outreach activities to TennCare enrollees. By agreement with the Bureau of TennCare, county staff bill for advocacy activities based on the time spent in these activities on behalf of the enrollee. Examples of such activities include assistance in accessing medical care by identifying providers and setting up appointments; reminder phone calls to the enrollee so that appointments are kept; assisting enrollees in understanding the TennCare system and appealing, when a medically necessary service is denied; and educating enrollees about the important concepts of a medical home, a primary care provider, the proper use of a hospital emergency room, preventive health education, rights and services under a managed care system.

The Department of Health is in the process of developing a community outreach project to increase awareness of the availability and importance of EPSDT services. This project will be a significant expansion of EPSDT services and will be targeted to a broader population of enrollees than those who are seen by the local health department clinics. The project will have specific components designed to reach teens. The statewide project will use public health educators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

#### c. Plan for the Coming Year

Departmental activities related to children and insurance coverage described previously will continue: enrollment of pregnant women in TennCare under presumptive eligibility; enrollment of CSS children in TennCare and assistance with access to care by the care coordinators; provision of EPSDT screenings for TennCare children; outreach and advocacy activities for TennCare enrollees; provision of primary care services in those counties with gatekeeping TennCare contracts; and referral of children/families to DHS for TennCare enrollment. The new EPSDT outreach project will be implemented statewide.

**Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.***

**a. Last Year's Accomplishments**

All Medicaid children are enrolled in the state's managed care program called TennCare. All TennCare recipients ages birth to 21 years of age are eligible for preventive health care screenings under the EPSDT program. Data from TennCare show that all children enrolled in TennCare received a paid service during 2003. Data are not available to estimate how many children in the state are potentially eligible for TennCare but who have not elected to enroll. June 2003 data from TennCare show that 57.9% of children ages 0 to 21 received a complete EPSDT exam during the year.

The Department of Health is helping insure that all TennCare children are receiving this important health care service. TennCare requires every MCO to contract with local health departments for EPSDT screening services. In FY 2002, the local health departments provided 43,512 EPSDT screenings. In FY 2003, the local health department clinics provided 51,845 EPSDT screenings.

Effective June 15, 2003, the Department of Health assumed the responsibility for screening all EPSDT eligible children in the custody of the Department of Children's Services (DCS). Data from DCS for April 2003 -- March 2004 show the 90.4% of children had completed EPSDT appointments within the past year (8,917 children). In addition, non-eligible children are also screened according to the AAP periodicity schedule.

**b. Current Activities**

June 2004 data from TennCare show that all children ages 0 to 21 received a service paid by Medicaid. Data also show that the EPSDT screening rate for these children had remained about the same as 2003 -- at 56.3 percent. The screening rate for children less than one year of age was 62 percent. Much emphasis is being placed on improving the screening rates, including a direct agreement between TennCare and the Department of Health to provide screenings in local health department clinics without the need for prior authorization by the primary care provider. Results are then reported to the PCP. It is projected that approximately 60,000 screenings will be done in FY 2004 in local health department clinics.

Health department clinic staff have continued to provide outreach and advocacy activities for TennCare enrollees. Examples of such activities include assistance in accessing medical care by identifying providers and setting up appointments; reminder phone calls to the enrollee so that appointments are kept; assisting enrollees in understanding the TennCare system and appealing, when a medically necessary service is denied; and educating enrollees about the important concepts of a medical home, a primary care provider, the proper use of a hospital emergency room, preventive health education, rights and services under a managed care system.

The state maintains a contract with the Tennessee Chapter of the American Academy of Pediatrics to provide outreach to and education of pediatric providers. This includes site visits as well as participation in professional conferences to educate providers about EPSDT services and screening guidelines, as well as coding and billing procedures.

Other sections of this document provide additional information on EPSDT services in the state and the role of the local health department clinics and the Title V agency.

**c. Plan for the Coming Year**

All local health department activities described above will continue.

The Department of Health is in the process of developing a community outreach project to increase awareness of the availability and importance of EPSDT services. This project will be a significant expansion of EPSDT services and will be targeted to a broader population of enrollees than those who are seen by the local health department clinics. The project will have specific components designed to reach teens. The statewide project will use public health educators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

The Department is currently planning to implement a EPSDT outreach call center that will phone TennCare families who have children eligible for EPSDT screening services. The outreach operators will provide education regarding the importance of preventive services; offer assistance in scheduling EPSDT appointments with either the child's primary care provider or the local health department; offer assistance with other TennCare issues; and document the outcome of the call. The call center will be staffed with 12 managed call operators and one bilingual operator.

**Performance Measure 15: *The percent of very low birth weight infants among all live births.***

**a. Last Year's Accomplishments**

Programs providing services for the high risk perinatal population include the perinatal regionalization system (24-hour consultation, transportation, professional education for providers, and technical assistance to facilities and providers); pregnancy testing in all county health department clinics with referral and coordination with private health care providers; prenatal care clinics in selected county health department sites (13 in FY 2003); WIC and nutrition services available in all counties; TennCare eligibility for all pregnant women under 185% of the poverty level; and home visiting programs for pregnant women. The purposes of the home visiting program are to reduce infant mortality and morbidity; serve as a care coordination service; assure that EPSDT exams are received; provide coaching and modeling of appropriate parenting techniques, and instruction in infant stimulation and child development; and assist the mother with selecting and following a family planning method in order to space pregnancies. Fiscal year 2003 data show that the program made 2,542 home visits to pregnant and postpartum women.

The WIC program targets pregnant women as the highest priority; an average of 20,000 pregnant women receives WIC services monthly. Data for April 2004 show a caseload of 20,385 pregnant women (13.1% of the caseload). The data show that 23.8% of the WIC caseload of pregnant women are African American.

The state has 5 regional perinatal centers providing specialty care for high risk pregnant women and infants and consultation to and education for health care providers within the respective geographic area. An advisory committee, coordinated by MCH, advises the Department on perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for perinatal nurses and social workers.

During 2002-2004, March of Dimes invested \$300,000 in a smoking cessation program (S.M.A.R.T. Moms), implemented in WIC clinics with pregnant women. The project has focused on training public and private health care providers to educate and assist clients in stopping smoking and on providing tools and educational materials for clients. This project has enhanced the intervention and education which has traditionally been a part of the WIC

program.

Given the effects of smoking during pregnancy on infant morbidity and mortality, in 2002 a work group was established within the Department under the Tobacco Prevention Program within the Community Services Division to find ways to reduce smoking during pregnancy. Work group members represent MCH, WIC, American Cancer Society, and March of Dimes. 17% of women report smoking during pregnancy. Efforts included promotion of the American Legacy Foundation quitline and SMART Moms and working towards establishing a Tennessee quitline.

#### b. Current Activities

All programs described previously continue.

All clinics are required to offer walk-in pregnancy testing to the extent possible in each site and to maintain up-to-date referral mechanisms for assisting clients with positive pregnancy tests. In 2004, 12 counties offer full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients, who are then delivered by private physicians. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery services and enrolled in WIC or CSFP, the two food and nutrition programs. If available in their county, they are assessed for eligibility in a home visiting program.

Data from the S.M.A.R.T. Moms project show that over 240 health department staff in all rural and metropolitan public health regions have completed training. Over 11,700 health care providers have received information on the project in a variety of settings. Over 5,268 pregnant smokers in WIC clinics received information about S.M.A.R.T. Moms, and 79% enrolled. Pregnant smokers who received the guide were more likely to quit smoking than those who did not (24% vs. 19%).

Tennessee has an agreement with the National Cancer Institute to provide the state with a smoking cessation quitline. Pregnant women who call this line are connected with the Great Start Quitline and its staff who are trained in smoking cessation for pregnant women. Tennessee provides radio and print advertising for the quitline.

Maternal smoking cessation has been named by the Commissioner of Health as a selective element that regions in Tennessee may choose to reduce infant morbidity and mortality. With this special emphasis, it is hoped that significant impact will be seen.

Extensive work occurred to revise the guidelines for the home visiting program, allowing increased flexibility on client selection and individualization of the services needed. Training on the new guidelines was provided in each region. Data for July 2003 through May 2004 show that the home visiting program made 3,745 visits to pregnant and postpartum women, a substantial increase over the past year.

As previously discussed (Overview of the State section), the Department of Health is in the process of developing and implementing a major initiative to address six areas in which Tennessee compares unfavorably with other states and in which there are wide gaps in the rates for various racial and ethnic populations. Those components of the LifeStart/LifeStyle Initiative which address infant mortality, adolescent pregnancy, and prenatal care are designed to improve perinatal outcomes.

The Perinatal Advisory Committee and a taskforce of perinatal nurses revised the perinatal manual "Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport" during this year. The document was placed on the Department's web site, and copies were distributed statewide.

### c. Plan for the Coming Year

The Department will continue to provide the services described above (perinatal regionalization, pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, enrollment in TennCare under presumptive eligibility, and TennCare outreach and advocacy). Counties across the state will be implementing the LifeStart/LifeStyle Initiative.

The S.M.A.R.T. moms program with March of Dimes funds will continue until the end of 2004; future funding is being sought.

The Perinatal Advisory Committee will be finalizing work on the revisions to two of the perinatal manuals (the regionalization guidelines and the educational objectives for social workers in perinatal care).

During this past year, the March of Dimes launched its national campaign to decrease the rates of prematurity. Numerous providers and organizations across the state are participating in the planning of events and activities focusing on raising the awareness of providers and the general public of the problem, counseling patients to recognize the signs of prematurity, and developing action strategies. As a part of this campaign, the March of Dimes is sponsoring a Prematurity Summit this fall to be held in conjunction with the Tennessee ACOG Chapter and the Association of Women's Health, Obstetrics and Neonatal Nurses Chapter. Numerous public and private providers will be involved in the Summit and other prematurity campaign activities.

#### Background data:

For the past 10 years, Tennessee's very low birth weight rate has fluctuated between 1.4 and 1.7% of the births. The actual for 2002 was 1.7% of births, indicating no appreciable change in the percentage of very low birth weight babies. Tennessee has targeted populations at risk of adverse pregnancy outcomes for many years. In recent years, the state has focused on addressing access to prenatal care for TennCare enrollees and those without access to insurance, primarily undocumented persons. Approximately 49% of births are to women on TennCare.

2002 very low birth weight births for the TennCare population were 2.1% of total TennCare births. This percent compares to the total state percent for 2002 of 1.7. Data on TennCare Medicaid enrollees on low birth weight births in 2002 show a very slight increase in the rate over 2001 for the Medicaid population (11.2 to 11.3). The rate for 2002 decreased slightly in the white population (9.8 to 9.3), but increased in the black Medicaid population (13.4 to 15.3).

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

### a. Last Year's Accomplishments

The suicide rate for this age group has fluctuated between 10.2 and 8.7 per 100,000 for the last 10 years (1992-2002). 2002 data show 35 deaths from suicide in the 15 to 19 year old group -- 8.7/100,000. From 1990-1992 the suicide rate averaged 10.2 per 100,000 and the average number of suicide deaths was 36.3. From 2000-2002 the average rate was 9.2 per 100,000, and the average number of suicide deaths was 36.7.

The Director of Adolescent Health in MCH has partnered for several years with the Tennessee Suicide Prevention Network (TSPN) to address youth suicide prevention. She co-chaired the

sub-committee on youth suicide prevention. Committee members developed a youth suicide prevention plan for the state. Network members are currently implementing components of the plan throughout Tennessee. As a member of TSPN, the Director of Adolescent Health participates on an intra-department suicide prevention work group that meets bi-monthly.

Youth suicide prevention brochures were distributed to all Nursing Directors working in public health throughout Tennessee for distribution in their local health department clinics.

#### b. Current Activities

The Director of Adolescent Health coordinated Tennessee's efforts to participate in the Region IV Suicide Prevention Conference that was held in early December 2003 in New Orleans. Fourteen people from Tennessee attended this conference; participants focused on additional development of the state plan to address suicide prevention.

Coordination with the Tennessee Suicide Prevention Network has continued for this year. A planning retreat with members of the Tennessee Suicide Prevention Network will take place this June 2004.

A youth suicide prevention fact sheet will be printed and distributed this year. The 1-800-SUICIDE poster has been posted in the Maternal and Child Health section for ready reference for all staff and callers.

#### c. Plan for the Coming Year

The Director of Adolescent Health will continue to partner with the Tennessee Suicide Prevention Network to address suicide prevention issues and youth suicide prevention issues in particular. In July 2004, the Director of Adolescent Health will participate in a statewide QPR (Question, Persuade, and Refer) "train the trainers" training. This training is a nationally recognized suicide prevention program for gatekeepers. She has committed to providing 500 people with the QPR training during the 2004/2005 fiscal year. Specific commitments within MCH that were identified through the intra-departmental work group for this coming year include:

Director of Adolescent Health (Maternal and Child Health section) will advertise the 1-800-SUICIDE hotline number and TSPN website address in each Adolescent Health newsletter (2 per year) distributed in 2004.

Director of Adolescent Health will print the 1-800-SUICIDE hotline number and TSPN website address in 275,000 youth health guides that will be distributed during 2004 and 2005 to pediatricians, family practice physicians, alcohol and drug abuse prevention counselors, child and adolescent psychiatrists, public health educators, public health nurses, school nurses, CSS care coordinators, adolescent pregnancy prevention coordinators, alcohol and drug prevention program staff, coordinated school health pilot sites staff, wellness teachers, Department of Children's Services case workers, youth ministers, and nonprofit youth workers. Distribution of these guides has begun.

Director of Adolescent Health will distribute regional suicide prevention resource directories to all health departments in Tennessee.

Maternal and Child Health staff will assist TSPN staff to help improve the accuracy of suicide attempt reporting data.

**Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.***

**a. Last Year's Accomplishments**

Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by the Health Statistics Office of the Department. The definitions for determining what level of care is provided by a facility have changed over the past few years. In 1999, data were collected from all Tennessee hospitals as a special perinatal supplement to the 1998 Joint Annual Report of Hospitals. This report is a joint effort between the Department of Health and the Tennessee Hospital Association. The information on the facilities by level of care is only used for statistical analysis purposes. Since the 1998 report, the questions have been a permanent component of the questionnaire. Data for 1998 show that 78.8% of the very low birth weight babies born in 1998 were delivered in tertiary care centers. 1999 and 2000 data show a percent of 78.9, indicating no appreciable change. Data for 2001 and 2002 show a decline (74.3 percent for 2001 and 74 percent for 2002).

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation to all health care providers within the respective geographic area. This system has been in place in the state since the 1970's and is well established and recognized. An advisory committee, established by legislation and coordinated by MCH staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area.

The changing health care environment may have played a role in the decrease in the percent of VLBW infants being born in a tertiary level hospital. However, there are also difficulties in capturing data on the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory. All services within the regional perinatal centers continued during the past year. MCH staff continued to work with the Perinatal Advisory Committee to review and revise the guidelines. During 2003, the "Educational Objectives for Nurses, Levels I, II, III, and Neonatal Transport" were revised, reprinted, and distributed statewide. The document was also placed on the Department's website for easy access by health care providers and facilities.

**b. Current Activities**

The structure of the five regional perinatal centers continues to be in place. The state (TennCare) contracts with each of the centers to support the infrastructure of the centers (consultation, professional education, maternal-fetal and neonatal transport, post-neonatal follow-up, data collection, and site visits to hospitals upon request). Staff at all centers are available to all health care providers to provide consultation, assistance and referral for any high risk pregnant woman or infant. The revision to the regionalization guidelines will be completed this year. The manual, "Educational Objectives in Medicine for Perinatal Social Workers" is in process and will be printed, distributed, and placed on the web site.

**c. Plan for the Coming Year**

The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise guidelines as needed. This committee will meet at least twice during the year and more often as needed. Committee members have been briefed by the Commissioner of Health about the Department's new LifeStart/LifeStyle Initiative and challenged to become active

partners in implementing activities within communities which will impact perinatal outcomes.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

#### a. Last Year's Accomplishments

2002 data show that 80.4% of pregnant women started prenatal care in the first trimester; these data show only a slight change from 2001 (80.5). Data on the TennCare Medicaid population show that for 2001 71.2% of their enrollees entered care in the first trimester and 74.7% for 2002.

Efforts to improve the rates of entry into prenatal care have concentrated on systems development and access to care issues. Prior to 1994 local health departments provided extensive prenatal care through their clinics and in cooperation with physicians who agreed to provide labor and delivery services at local hospitals. Concurrent with these services, the statewide perinatal system developed a system to provide referral and treatment for problem pregnancies. The goal of the local health department and perinatal system effort is to assure that pregnant women have access to the level of care they need, based on the condition of their pregnancy. Under managed care, the delivery of prenatal care shifted from local health departments to the private sector in all but a few counties (13 for FY 2003). Activities targeting this performance measure include: pregnancy testing in all health department clinics with appropriate referrals; presumptive eligibility for TennCare in all sites; prenatal care in those counties not served adequately by the private sector (services primarily are being provided to Hispanic pregnant women who are not eligible for TennCare); WIC/nutrition services; West Tennessee's Campaign for Healthier Babies; Tennessee Home Visiting Program; and the Perinatal Regionalization System. In West Tennessee, an MCO has contracted with the health department for prenatal and postpartum home visiting as a means of improving pregnancy outcome.

The Campaign for Healthier Babies, operating in Memphis/Shelby County and rural West Tennessee, is a media and educational effort to increase the incidence of prenatal care and improve birth outcomes. Distribution of the Happy Birthday Baby Book began in Memphis in 1993. The campaign centers around a toll-free number promoted through television, radio, newspaper, mass transit ads and printed materials. Pregnant women call the number to receive a free book of information and merchandise coupons which are validated at the prenatal visits. Women in the rural counties are provided the coupon book through the local health department clinics. In 2003, over 12,100 phone calls were received at the Shelby County Health Department, 9,777 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (22,500 brochures), were mailed during the year. Coupon books were also distributed in the rural counties. In 2003, the Campaign reached 79.9% of the target audience (women 18-49) an average of 11.13 times per quarter. There were 1,811 sixty-second television spots aired with 835 purchased and 976 donated. There were 9 active campaign partners. Over 1.7 million people either saw or heard the messages.

#### b. Current Activities

All previously described activities continued into the current year. Emphasis continues to be placed on reaching the Hispanic pregnant women and assisting with prenatal care or arranging referrals to the private health care providers within the community. Twelve counties are offering full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery services. They are also enrolled in WIC or CSFP, the two supplemental food and nutrition programs in the state. Data

on WIC clients for April 2004 show that 20,385 pregnant women were participating in the program. If available in their county, the clients are assessed for the need for home visiting services and referred to the program.

As previously described, the Department is developing a statewide Initiative (LifeStart/LifeStyle) to address selected indicators on which Tennessee compares unfavorably with other states and for which the disparity between population groups is wide. One of these is prenatal care. Regions and counties are currently working on action plans to address the areas of concern.

### c. Plan for the Coming Year

All previously discussed activities will continue into the coming year. Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems.

## FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

### General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Screen all infants born in Tennessee for those diseases determined by the Genetics Advisory Committee, the Department and state law.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Follow up on all infants needing a repeat test or further diagnostic work.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Work closely with Genetics and Sickle Cell Centers on follow-up and treatment.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Work closely with all birthing facilities and health care providers on newborn screening testing and results.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide educational materials for parents and providers on newborn screening tests.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Assist with re-evaluation of cut-off values for testing.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels				

and are satisfied with the services they receive. (CSHCN survey)				
1. Partner with groups who are advocates for children with special health care needs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. In conjunction with the child's family, develop a Family Service Plan for each child enrolled in the program.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Include parents on the CSS Advisory Board.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct annual parent satisfaction surveys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Provide care coordination services to each enrolled child and his/her family.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assist families moving from or to other states and needing CSHCN services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide training and technical assistance to CSS staff statewide as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Use the monitoring system to identify each child's medical home or the need for one.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to educate local primary care providers on the medical home concept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Assure that all children applying for CSS services also apply for TennCare.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide care coordination services to all CSS families statewide, assisting families with access to medical care, utilization of services, transportation, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Assist families with any needed appeals to TennCare for denied services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Work with TennCare, the managed care organizations, and providers to ensure service needs of this special population.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Coordinate CSS services with other health department services (i.e., scheduling access, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Work with regional and local health councils to identify needs and gaps in services in specific communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with state agencies such as the Departments of Mental Health/Developmental Disabilities, Education, and Mental Retardation, local mental health centers, and school systems to develop a system of care approach to services for the population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct annual parent satisfaction surveys.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Include transition services in the individual care plans for those clients approaching adulthood.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintain listing of community referral resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assist with all appropriate referrals for these clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Train CSS staff on transition issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Provide immunizations in local health department clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Check immunization status of persons requesting any type of service at local health department clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maintain and continue to improve the Immunization Registry software and capability for electronic access for submission and retrieval of data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Use intranet connection to increase data input by private physicians to the Registry.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Assess immunization coverage levels in the population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Immunization staff continue to work with providers within their geographic areas providing technical assistance.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide family planning services in all 95 counties.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide education in community settings related to adolescent health and prevention of risk-taking behaviors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue TAPPP coordinators' activities and coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue the Abstinence Only Education Program community-based projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue the Community Prevention Initiative programs targeting children 0-12 at high risk for becoming involved in self-destructive behaviors.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Emphasize services for adolescents through the LifeStart/LifeStyle Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Provide clinical dental services to TennCare children.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide preventive dental services, including sealants and oral health education, to children in schools.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide dental outreach activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide dental services using the three mobile units in Northeast, Mid Cumberland, and West Tennessee Regions.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Implement the fluoride varnish program.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Educate health department staff and the general public about the new child safety seat law.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide child safety seat checks at local health departments and other community sites.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Conduct injury control activities on seat belts and child safety seat usage.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Partner with local law enforcement agencies, Safe Kids Coalition, Head Start Centers, school systems, and the Governor's Highway Safety Office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide education to students, train providers, participate in exhibits and health fairs, and others as requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Breastfeeding coordinators and advocates in every region work with				

health care providers, health department staff, and postpartum women to assist and promote breastfeeding.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Data on breastfeeding in WIC clients are routinely collected.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. A USDA infrastructure grant is allowing more intensive data collection and evaluation efforts. Three years of data will be evaluated in the fall.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The Baby Friendly Initiative is being implemented in local health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. A USDA grant is promoting breastfeeding using social marketing principals in rural West Tennessee.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Promote newborn hearing screening in all birthing facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Promote the use of the data collection system by all birthing facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide technical assistance and education to providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop guidelines for audiologic assessment and amplification.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Coordinate referrals and follow-up on infants with abnormal results.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Coordinate the activities of the Newborn Hearing Screening Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Distribute educational material for parents, providers, facilities, and intervention programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Provide outreach and advocacy services in all health department clinics for TennCare enrollees.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide EPSDT screenings for TennCare enrollees.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide EPSDT screenings for children in state custody.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Implement the EPSDT community outreach project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide presumptive eligibility for pregnant women in all health department clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Assist all children applying for CSS services with enrollment in TennCare.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Assist TennCare enrollees with the TennCare appeals process.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Assist the TennCare program with marketing the need for EPSDT screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide EPSDT exams in all local health department clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide outreach and advocacy services for TennCare enrollees.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide EPSDT screening exams for all children in the custody of the Department of Children's Services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Implement the EPSDT community outreach project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Continue all activities of the Perinatal Regionalization System (5 regional centers).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide pregnancy testing, counseling, referrals, and presumptive eligibility for TennCare enrollment in all health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide WIC/Nutrition services in all local health department clinics (all counties).	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide outreach and advocacy for TennCare enrollees.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide home visiting services for pregnant women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Offer comprehensive prenatal care services in 12 counties.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue S.M.A.R.T. Moms smoking cessation project in all WIC clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				

1. Assist with Suicide Prevention Awareness Day.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Partner with the Suicide Prevention Network.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Serve on the Network subcommittee on youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assist with implementing the state youth suicide prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Develop and distribute a fact sheet on adolescent suicide prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Provide training on youth suicide prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Distribute youth health guides statewide to providers and youth (suicide information is included)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Continue the perinatal regionalization system.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Coordinate the activities of the Perinatal Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Update and revise perinatal program manuals as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Provide pregnancy testing, counseling, referral, and presumptive eligibility in all local health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide comprehensive prenatal care in 12 counties.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide WIC/nutrition services in all local health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Work with the Campaign for Healthier Babies in West Tennessee.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement action plans for early entry into prenatal care developed as a part of the LifeStart/LifeStyle Initiative.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### D. STATE PERFORMANCE MEASURES

**State Performance Measure 1: *After implementation of folic acid education at the state, regional, and local levels, reduce the number of neural tube defects births.***

##### a. Last Year's Accomplishments

Programs and health system activities that support this performance measure are the MCH/Nutrition collaboration for the folic acid campaign; family planning services in all 95 counties of the state; WIC clinics and nutrition classes; collaboration with the March of Dimes on the folic acid campaign and public information; media releases; Children's Special Services program for care coordination of those with neural tube defects; and the establishment of the new Tennessee Birth Defects Registry (TBDR). In the spring of 2003, the TBDR released for the first time statewide counts of 43 major birth defects tracked by the National Birth Defects Prevention Network (NBDPN) and the Centers for Disease Control and Prevention (CDC).

Folic acid education activities have continued with distribution of printed materials, emery boards, and bookmarks, workshops, media, web sites, paycheck messages, and exhibits. About 46,000 were reached through four women's shows or parenting fairs in the state. Many others attended statewide health department "baby fairs" and other events and meetings which included folic acid information. About 40,000 persons received paycheck messages (twice) and a payroll insert on folic acid. One metro health department developed a bus ad campaign in May which included a folic acid message. At the end of last year, the Department was awarded \$411,000 from the Vitamin Settlement Funds; these funds were for the purchase of multivitamins with folic acid. These vitamins are being distributed through family planning, WIC and other health department clinics.

The Department is responsible for coordinating and chairing the Tennessee Folic Acid Council (TFAC) and coordinating two March of Dimes folic acid grants. The two-year Folic Acid in the Workplace and Professional Education grant funded two projects: (1) folic acid workshops on-site in six major employers reaching 19,850 workers, and (2) a continuing education program for physicians. A Hispanic physician on the council worked with Radio Ambiente (estimated 20,000-30,000 listeners) to promote folic acid several times during 2003. The Department's Office of Minority Health sent a folic acid message to the statewide Latina Network (35-40 members).

##### b. Current Activities

Previously discussed activities are ongoing. The Leadership grant continues through June 2004 and has funded Council activities including the development of the CME offering in a mixed media CD format (audio, PowerPoint, and PDF file) which was mailed to over 5,800 physicians, physician assistants and osteopaths. Folic acid press releases in English and Spanish were prepared and distributed to media in the Memphis area in January. Staff, along with other TFAC members, are working to expand the continuing education program to other health professionals, including dietitians and nurses. Efforts are also underway to place the continuing education offering on the Department's web site, the first such offering on the site. The Department's folic acid materials were distributed at the Southern Women's Show in Nashville this spring and at the Kingsport Expo for Women. In August, the Department is one of the sponsors of the All About Women health event which has an expected attendance of 20,000 Middle Tennessee area women. Folic acid is one of the topics to be highlighted at this event.

Department staff and TFAC partners worked to develop materials ("How to Choose a Multivitamin" and "Eat Smart, Move More, Tune In and Take a Multivitamin for Folic Acid Every Day") and incentives (compact mirrors with a folic acid message; 10,000 have been ordered) appropriate for adolescent girls. These were developed primarily for use with cadette and senior Girl Scouts. About 1,000 Girl Scouts and leaders (over 300 were cadette and senior level) attended a recent Mall Madness overnight event at a mid-state mall. TFAC had a booth promoting the folic acid badge, available workshops and information on nutrition and folic acid specifically. Tennessee, working with Girl Scouts and the National March of Dimes office, developed a badge specific for folic acid education. The Girl Scouts Cumberland Valley Council included the folic acid information at camp leader training in May. Other workshops and leader training sessions are scheduled for later in the year.

To date this year, 62,338 bottles of 250 multivitamins and 5,664 bottles of 50 multivitamins have been purchased for statewide distribution in health departments.

The creation of the Tennessee Birth Defects Registry provides a more accurate look at NTD prevalence. According to "Tennessee Birth Defects Counts: Year 2000", 30 cases of anencephaly and spina bifida were reported. These were for infants born and diagnosed in 2000. The TBDR is in the process of adding to these estimates with data from 2001 and 2002. The TBDR is collaborating with the NBDPN and the CDC to develop an effective birth defects monitoring and prevention program in Tennessee. During 2000 and 2001, anencephaly resulted in 15 deaths in Tennessee. In 2000, spina bifida was associated with over \$11 million in health care costs at Tennessee hospitals and clinics.

Note that the data provided on Form 11 are from birth certificates in order to provide trend data.

#### c. Plan for the Coming Year

The Department, partnering with the Tennessee Folic Acid Council members, the March of Dimes, and local health department staff, will continue folic acid education activities as a major focus. Next year activities will include continuation of workshops, materials and exhibits; expanding the continuing education offering to additional health professionals and providing the offering on the Department's web site; and distribution of multivitamins through family planning, WIC and other health department clinics for non-pregnant women. Plans are also being made to provide educational materials on folic acid to college and university students through the health centers and to offer education materials for distribution at the county offices issuing marriage licenses. Building on the recent events with the Girl Scouts (camp training and Mall Madness), it is expected that the coming year will include numerous workshops and leader training sessions.

**State Performance Measure 2: *Reduce to no more than 4% elevated blood lead levels in children 6-72 months of age who are screened.***

#### a. Last Year's Accomplishments

The Tennessee Department of Health received three one-year grant awards from the Centers for Disease Control and Prevention to implement a Childhood Lead Poisoning Prevention Program (CLPPP) beginning July 1, 2001. The goal is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Program goals are four-fold: a) Monitor all blood lead levels of children less than 6 years old; b) Increase screening of children at high risk of lead exposure; c) Assure proper follow-up for children with elevated blood lead levels; and d) Increase public awareness of childhood lead poisoning and prevention. CLPPP resources are targeted to areas of highest risk of childhood lead poisoning based on old housing, children

in poverty, and number of low income housing units.

Contracted partners are integral to CLPPP: The CLPPP Medical Director, located at The University of Tennessee-Memphis, provides consultation to health care providers regarding medical case management of children with lead poisoning. The University of Tennessee Extension Service provides CLPPP primary prevention education to the general public, parents, child care educators, 4-H and other youth, underserved and minority populations. The Tennessee Department of Environment and Conservation conducts environmental investigations for children with elevated blood lead levels (EBLL).

Tennessee law requires that laboratories doing business in the State report all blood lead levels to TDH. The data are entered into a new data management system at The University of Tennessee Safety Center. Children with blood lead levels  $>10 \mu\text{g/dl}$  are entered into a case management system and followed until case closure through the efforts of local health departments as well as private clinics.

CDC approved \$890,000 for CLPPP for FY 2003-04, the first year in a three year grant cycle. Emphasis was placed on establishing the new electronic data surveillance system.

The Memphis/Shelby County CLPPP, which had been funded separately by the CDC previously, was integrated into the state program effective July 1, 2003.

In calendar year 2003, a total of 51,595 blood lead screening tests were given to children under the age of six in Tennessee. Of those tested, 199 had lead poisoning (a confirmed elevated blood lead level  $= 10 \mu\text{g/dl}$ ).

Of the confirmed positive cases, Shelby County had the highest number of lead poisoning cases with 67 (34%), Davidson County had the next highest with 17 (9%), Sullivan County was next highest at 10 (5%), followed by Hamilton and Bedford Counties with 8 (4%) each.

#### b. Current Activities

All activities described in the previous section continued (screening, follow-up, and education). The Department of Health has agreements with all of the TennCare managed care organizations (MCOs) to provide some traditional public health services, including blood lead screening of children, without prior authorization. Local health departments continue to play a critical role in assuring access to needed services through outreach and advocacy activities. Central office provides assurance of case management. A protocol for screening pregnant women is in development.

#### c. Plan for the Coming Year

All activities described above continue (screening, follow-up, and education). Specific objectives for fiscal year 2004-05 include: a) Matching Tennessee Medicaid/TennCare data with the CLPPP database; b) Increased partnering with community organizations and with other state/local agencies involved in environmental and child health activities; c) Collaborating with organizations and agencies involved in lead-based paint hazard reduction activities to develop protective policy and to reduce lead hazards in at least 75 housing units; d) Educating 500 professionals about the Environmental Protection Agency's lead-based paint notification rule and recommended practices related to lead hazard containment/clean-up; and e) Restructuring CLPPP so that essential program elements can be conducted even if funding is further reduced.

State Performance Measure 3: *Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).*

a. Last Year's Accomplishments

The Department, through activities of the Community Services Section and the Bureau of Alcohol and Drug, addresses the issue of tobacco use by youth. The Tobacco Use Prevention Program partners with many organizations, school systems and health care systems, to provide education to our youth. The 2003 Youth Risk Behavior Survey (YRBS) indicated that 35.3% of Tennessee high school students are current tobacco users. The 2003 YRBS reveals current smokeless tobacco use (smokeless tobacco used in at least 1 of the past 30 days) for high school students at 7.5% with males using smokeless tobacco at a rate of 14%.

Tennessee's program to reduce initiation of tobacco use by youth and promote quitting in this population uses a multi-component approach. Program initiatives are both school and community based. The program focuses on changing the social norm to support non-tobacco use rather than focusing totally on individual behavior. Community interventions, including empowering community youth to work on the problem of tobacco use, earned and paid media counter marketing campaigns and promoting policies which support non-use are all part of the program.

Through the Bureau of Alcohol and Drugs, the Department of Agriculture is contracted to perform both the SYNAR checks for compliance with the Youth Access Act of 1994 and conduct a Youth Access Enforcement project. The Director of the Tobacco Use Prevention program is on the advisory board of the SYNAR project. The departments collaborate to provide education to both the retailers and the community on the importance of non-sale of tobacco products to minors. Stopping retailers from selling to minors will not stop youth from obtaining tobacco products, but it will create a community environment which supports non-use for youth. Youth groups funded by the Tobacco Use Prevention Program perform the reward and reminder program which addresses compliance to the Youth Access Law.

In 2003, the program had 42 active youth groups implementing community and school based activities. Several communities have partnered with the Juvenile Justice system to incorporate tobacco prevention education sessions into programs for tobacco possession violations. The American Lung Association's Teens Against Tobacco Use (TATU) and the American Academy of Pediatrics' Tar Wars Program are still being used in many schools. Over 40 communities participated in youth "Great American Smoke Out" and "Kick Butts Day" activities. Over 200 youth from across the state participated in "Youth Day on the Hill" where youth received advocacy training and visited their representatives expressing their support to increase the cigarette excise tax.

b. Current Activities

The 2003-04 is the last year of the three year community-funded youth groups projects. These groups continue to work on the policy initiatives of Tobacco-Free Schools and Youth Access to tobacco products. The focus of Tobacco-Free Schools is to gain community support for compliance by both youth and adults not using tobacco on school grounds. The Youth Access initiative focuses on retailers being good role models to youth by not breaking the law and selling tobacco products to youth under the age of 18. Compliance to both of these policies will provide an environment which support non-tobacco use by youth. In September 2003 the program held its third annual Youth Tobacco Summit for 150 youth from across the state. Over 100 youth from across the state attended the state coalition's "Youth Day on the Hill". The youth received advocacy training, participated in a committee session and visited their representatives expressing their support for the repeal of preemption and increasing the cigarette excise tax.

### c. Plan for the Coming Year

In 2004-05 new guidance and direction for funding opportunities for local tobacco prevention will be developed, and 12 new agencies will be funded to focus on policies to support non-tobacco use. The focus of these new grants will continue to work toward providing an environment in the community which supports what the youth are learning through educational efforts about non-tobacco use as a norm. These grants will differ from previous grants because each grant will be of sufficient value to support a part time staff member depending on the size of the community. The 2004 Youth Tobacco Survey will be conducted in the fall. A new 5 year strategic plan will be developed to guide a statewide initiative to reduce youth tobacco use. Health educators will continue to partner with both coordinated school health sites, wellness teachers and community initiatives directors to provide prevention efforts to reduce initiation of tobacco use by youth. Cessation for our youth will continue to be addressed locally, and also as a statewide effort. Statewide addressing the issues of smoking during pregnancy is a high priority for action. Many of our young girls who become pregnant are also at risk for using tobacco products. Cessation will also be addressed statewide by an attempt to receive supplemental funds from the CDC to promote a national network of cessation telephone quitlines and to build capacity to create Tennessee's own proactive quitline in the future.

## State Performance Measure 4: *Reduce the percentage of high school students using alcohol.*

### a. Last Year's Accomplishments

The Bureau of Alcohol and Drug Abuse Services within the Tennessee Department of Health provides prevention services to young people throughout the state.

The Bureau of Alcohol and Drug Abuse Services, in collaboration with the Alcohol and Drug Council of Middle Tennessee, continued to develop coalitions across the state to reduce substance abuse among all population groups. In each grand division of the state, the Bureau funded a pilot prevention project. The mission of these projects was to test the recommended Center for Substance Abuse Prevention process for delivering and evaluating best practices prevention programs. The Bureau sponsors three regional Teen Institutes every summer for rising high school students. The Institute trains teams of four students and one adult advisor in alcohol and drug prevention strategies, information, personal growth and development courses and team building. Each of the three regional Teen Institutes attracts 100 - 180 participants per year. Also, an adolescent advisory committee continues to function as a collaborative partnership between the Bureau, service providers and agencies serving adolescents with alcohol and drug problems.

The Community Prevention Initiative for Children (CPIC) was established in Tennessee in 1996 to serve children from 0-12 and their families. The CPIC targets the reduction of high risk behaviors of youth such as teen substance use/abuse, teen pregnancy, teen violence, and school drop-out by providing prevention programs and services to children who are at highest risk for becoming involved in high risk behaviors in adolescence. The programs and services focus on reducing risk factors, enhancing protective factors and building resiliency through community-based prevention programs and services. Community members through the County and Regional Health Councils are directly involved in the planning, selection, implementation and review of the programs, services and activities provided.

In 2002-2003, the Community Prevention Initiative (CPI) funded 68 programs in 50 counties, including the four Metropolitan counties. The CPI program targets counties and census tracts in the metropolitan areas that have the highest incidence of high risk behaviors by youth based on data gathered through the community diagnosis process and the "Communities That Care"

model. The services and activities of the Community Prevention Initiative are community-based with community ownership. Community members through the health councils and/or advisory committees are directly involved in the planning, selection, implementation and review of the services and activities provided by each program provider in the region. The programs and services are community-based in order to provide for effective program and services that meet the needs of the identified priority populations. All CPI providers must have measurable goals, objectives, and performance measures to demonstrate impact and outcomes.

#### b. Current Activities

The Bureau of Alcohol and Drug Prevention Services is continuing the same type and level of services as described in the prior section. The Community Prevention Initiative is funding 70 programs this year. These programs are located in 51 counties and include the 4 Metropolitan counties of Knoxville, Chattanooga, Nashville, and Memphis. All of the previously mentioned activities were continued during this current year.

According to the 2002-2003 Youth Risk Behavior Survey (YRBS) 74% of Tennessee's high school students reported to have had at least one drink on one or more days during their lifetime. These rates increased with increasing age and grade. However there seems to be little difference across race or gender. 41.1 percent of high school students completing the survey reported having at least one drink of alcohol on one or more of the past 30 days. The percentage of students reporting binge drinking, defined in the YRBS as five or more drinks within a couple of hours, on one or more of the past thirty days, was 25.5%. The rate was eight percent higher for males than females, and increased with increasing age and grade. There are significant differences across gender and race for binge drinking behavior. White males and females are much more likely to have engaged in the behavior than are African American males and females. The highest rate reported, 35% was seen in white males, while the lowest rate (10.1%) was seen in African American females.

#### c. Plan for the Coming Year

The Bureau of Alcohol and Drug Abuse Services will continue with the same activities from 2003-2004 to address adolescent alcohol usage during 2004-2005. The Community Prevention Initiative will continue the same type and level of programming in 2004-2005 as was implemented last year.

**State Performance Measure 5: *Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.***

#### a. Last Year's Accomplishments

Programs and health system activities that support this performance measure are: the mandatory reporting system; investigation by the Department of Children's Services and prosecution; community based programs for prevention education; the Child Fatality Review System; and the county home visiting programs in local health departments and contract agencies.

Based on 2002 data the state's rate of substantiated child abuse and neglect cases is 4.5 per 1,000, significantly lower than the previous year. While responsibility for preventing and intervening in child abuse cases resides in the Department of Children's Services (DCS), MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program (CHAD), funded by DCS, offers

home visiting, parent training, infant stimulation and basic health care to families at risk or suspected or potential abuse and neglect in selected counties. The Healthy Start Program (Hawaii model) offers similar services through community based agencies targeting adolescent and first time mothers. The HUGS home visiting program provides services to pregnant women and families of infants and toddlers. All these home visiting programs offer the opportunity to educate and counsel families, and make referrals for additional services. All public health staff are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse. Children presenting to the local health departments for a variety of services, including immunizations, WIC, and EPSDT, are assessed for needed services related to prevention of abuse and neglect.

During FY 2002-2003, the Department provided CHAD in 41 counties. Families referred to this program often are referred by Child Protective Services. The Healthy Start Program provided home visiting services in 28 counties, targeting first time parents who are in the prenatal period or who are at or near the time of birth. The HUGS program is run through the local health departments and offers services in all regions of the state serving 70 counties. HUGS provides parent support, child development information, health care information and general parent education.

Tennessee has a statewide network of 11 Child Care Resource and Referral Centers (CCR&RC), each of which has a child care specialist with a focus on health. These centers provide technical assistance, training, and resources to child care providers. These consultants receive training concerning child abuse prevention, recognition, and reporting. In 2003 four new CCHCs and nine Head Start managers received this training. During 2003, 13,896 participants received 30,264 hours of training on child development, early childhood education, health and safety, behavior management, and child care administration through Tennessee Child Care Provider Training. Each licensed child care provider receives an annual visit from a CCR&RC specialist.

#### b. Current Activities

Due to funding cuts by the Department of Children's Services (DCS), the Child Health and Development Program (CHAD) will only serve 23 counties in fiscal year 2004. The program will provide home visit support to parents along with health and child development education.

The Healthy Start Program continued to provide services in 26 counties, although the number of families served will be lower due to reduced funding by DCS. Healthy Start created and installed a new data collection and reporting system in fiscal year 2004.

The HUGS Program continued to provide services to 70 counties and is accommodating more families due to the CHAD reduction in services. The HUGS Program has completed evaluating and updating its program structure. The new program guidelines have been completed and implemented in fiscal year 2004.

The Child Care Health Consultants provide training, technical assistance, and consultation to child care providers as needed in the areas of child abuse prevention, recognition, and reporting.

The state received an Early Childhood Comprehensive Systems Planning Grant June 2003 to create a network of representatives from public and private agencies working with children, evaluate current systems capacity, conduct a statewide needs assessment, and develop a long term plan for the state addressing the critical elements of the grant to achieve the goals of healthy growth and development and school readiness for all children. The state has contracted with the United Way for implementation of grant activities. Prevention and intervention related to child abuse and neglect is one key area of the grant activities.

### c. Plan for the Coming Year

All home visiting programs (Healthy Start, HUGS, and CHAD) will continue. The Healthy Start program will continue to improve the new data collection system. The new program provides the opportunity for better program monitoring and technical assistance both at the local and state levels.

Staff at the 11 Child Care Resource and Referral Centers across the state receive quarterly training. The November 2004 training, "Childhood Obesity," will be provided under the CISS -- Transitioning Healthy Child Care America Program. The CCR&RC are included in the Early Childhood Comprehensive Systems of Care (ECCS) that is in the planning stages at this time. Children in state custody due to child abuse or neglect are one of the key indicators in the ECCS and will continue to be a focus after the transition to the ECCS. The role of the CCR&RC is expanding to include more systems information as well as child care provider information. Also, one of our staff will attend the National Training Institute for Child Care Health Consultants September 29 -- October 2, 2004, at the University of North Carolina.

State Performance Measure 6: *Reduce the number of HIV infected infants to no more than one per year.*

### a. Last Year's Accomplishments

Programs that support this performance measure are: the state's Communicable Disease Surveillance System; the HIV/AIDS program; and Ryan White program for education, intervention and prevention of HIV/AIDS.

Primary responsibility for the reduction of HIV infected infants is within the HIV/AIDS/STD Program; however, there is strong collaboration between that branch and MCH. Both sections are located within the Bureau of Health Services. The directors of both sections attend bi-weekly meetings during which cross collaborations are discussed. Collaboration occurs on issues related to HIV/AIDS through the Children with Special Health Care Needs Program, Family Planning, EPSDT services, and prenatal care. Family planning and prenatal clinics at the local levels routinely make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS. MCH staff are available to assist the Ryan White All Titles committee which is part of the community groups involved in planning and decision-making for HIV/AIDS.

The Tennessee HIV Pregnancy Screening Act (January 1, 1998) required that all providers of prenatal care counsel pregnant women regarding HIV infection and the need for testing, test unless refused, and counsel those testing positive. The Perinatal Advisory Committee has assisted in the dissemination of HIV/AIDS information for pregnant women and newborns to providers in their regions.

For the last 5 years program staff have investigated those babies born to HIV positive mothers. Beginning in 1999, Tennessee received a CDC grant to perform these investigations. This process involved chart extraction directly from the hospital of delivery. Follow-up for those babies that did test positive was assured by the local health department. This grant was eliminated in 2003 and may impact future data collection. The approach will continue however with dependence upon local reporting. The process will include notifying high prevalence medical providers of possible missed opportunities in providing HIV testing and prevention.

All local health department clinics offer HIV counseling and testing services. All clinics also offer pregnancy testing and counseling; HIV testing is available to all clients testing positive for

pregnancy. In those counties providing full service prenatal care, HIV counseling and testing is offered as a standard of care. Clients receiving family planning services at all 129 sites are assessed for HIV/AIDS risk behaviors, counseled regarding risk reduction behaviors, and offered testing services.

#### b. Current Activities

All services described above continue to be available.

The Tennessee Department of Health continues to support the Pregnancy Screening Act established by legislation in 1998. This legislation requires all pregnant women to receive counseling regarding the importance of testing for HIV during pregnancy; that they be tested unless they refuse; and that those found to be positive be counseled on the importance of treatment. Counseling regarding the importance of treatment emphasizes both the health of the mother and the opportunity to avoid transmitting the virus to the unborn infant. The MCH section stands ready to collaborate further with the HIV/AIDS/STD program on perinatal HIV prevention projects.

New testing technology also provides a window to decrease possible infection even more. The rapid HIV test utilized in emergency rooms can expeditiously test those women who present for delivery without prenatal care. If a woman tests positive, antiretroviral medication can be administered immediately, giving the most at risk child a chance at being HIV negative. The HIV/AIDS/STD program, in collaboration with The University of Tennessee Medical Center, a high prevalence hospital in Memphis Tennessee, is in the process of implementing rapid HIV testing in the emergency room and labor/delivery. This initiative will have a positive impact on not only preventing perinatal infection, but also getting infected individuals into care earlier.

#### c. Plan for the Coming Year

All services described will continue.

Background data: Data on pediatric HIV and pediatric AIDS have been available continuously since 1986. In November 1986, the program began gathering data on the number of infants exposed during pregnancy and birth. At that time the numbers were very fluid. That is, the numbers changed as infants who were HIV negative at 1 year of age could seroconvert the next. Also, the collecting system was such that cases were sometimes reported well after the event.

In CY 1999, there were 117 perinatally-exposed infants in Tennessee. Of these 117 infants, 86 sero-reverted to normal (that is HIV negative). Five of the 117 infants remained HIV positive and became pediatric cases of HIV. In CY 2000, there were 126 perinatally-exposed infants in Tennessee. Of these 126 infants, 94 sero-reverted to normal (that is HIV negative). Six of the 126 infants remained HIV positive and became pediatric cases of HIV. These babies were in the Memphis area, born to drug abusing women who did not receive prenatal care. In CY 2001 there were 107 perinatally-exposed infants in Tennessee. Of these 107 infants, 62 sero-reverted to normal (that is HIV negative). Four of the 107 infants remained HIV positive and became pediatric cases of HIV. In CY 2002 there were 115 perinatally-exposed infants in Tennessee. Of these 115 infants, 69 seroreverted to normal (that is HIV negative). Six of these 115 infants remained HIV positive and became pediatric cases of HIV.

Data for 2003 has been hampered by the loss of CDC funding for detailed investigations of perinatal HIV cases across the state. Thus Tennessee will now rely on local reporting. Because of reporting delays, data for CY 2003 remains incomplete.

**State Performance Measure 7: *Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.***

**a. Last Year's Accomplishments**

All TennCare recipients ages birth to 21 years of age are eligible for preventive health care screenings under the EPSDT program. It is the Department of Health's responsibility to help insure that all TennCare children are receiving this important health care service. In an effort to reach the 80% target set for EPSDT screenings in Tennessee, the State has undertaken a number of steps to improve the EPSDT screening rate. One of these steps involves requiring every MCO to contract with local health departments for EPSDT screening services. The Tennessee Department of Health has entered into an interdepartmental agreement with the Bureau of TennCare to provide outreach and screening services. As a result, local health departments are under a mandate from the Department of Health to do everything possible to encourage parents to get their children screened and to offer screening services to families with children enrolled in the TennCare program.

Local health departments are offering EPSDT screening services to families whenever a child is in the health department for any kind of service (WIC, immunizations, etc.). It is sometimes difficult for a family to put a priority on preventive health services (taking their child to the doctor when the child is not sick). By offering the service while the family is already at the health department (no extra trip required), children who might not otherwise have received a well child check-up (EPSDT screen) will be served. If the parent expresses a desire to have their child screened, but does not have time on the day they are in the health department, staff will schedule an appointment for a later date. If the parent expresses a desire to have their child screened but prefers to receive the service from their designated PCP (primary care provider), health department staff will offer to assist the family in making that appointment.

Whenever a parent does choose to have the health department provide an EPSDT screen, a form is sent to the child's PCP to let him/her know that the screen was done and to notify him/her of any identified problem. If the child has a problem in need of immediate follow-up, health department staff will assist the family in making an appointment with the PCP or other provider recommended by the PCP.

In FY 2001-2002, the local health departments provided 43,512 EPSDT screenings. In FY 2002-2003, the clinics provided 51,845 EPSDT screenings; this was a nineteen percent increase in activity.

**b. Current Activities**

All screening and outreach activities described above continue to be provided statewide. It is projected that approximately 60,000 screenings will be done in FY 2003-2004.

As of June 15, 2003, the Department of Health assumed the responsibility for screening all EPSDT eligible children in the custody of the Tennessee Department of Children's Services (DCS). Data for April 2003 -- March 2004 from DCS show that 90.4 percent of children had completed EPSDT appointments within the past year (8,917 children). In addition, non-eligible children will continue to be screened according to the AAP periodicity schedule.

**c. Plan for the Coming Year**

All screening and outreach activities described above will continue to be provided statewide. It is projected that approximately 60,000 screenings will occur annually.

The Department of Health is in the process of developing a community outreach project to

increase awareness of the availability and importance of EPSDT services. This project will be a significant expansion of EPSDT services and will be targeted to a broader population of enrollees than those who are seen by the local health department clinics. The project will have specific components designed to reach teens. The statewide project will use public health educators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

The Department is planning to implement a EPSDT outreach call center that will phone TennCare families who have children eligible for EPSDT screening services. The outreach operators will provide education regarding the importance of preventive services; offer assistance in scheduling EPSDT appointments with either the child's primary care provider or the local health department; offer assistance with other TennCare issues; and document the outcome of the call. The call center will be staffed with 12 managed call operators and one bilingual operator.

### State Performance Measure 8: *Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics.*

#### a. Last Year's Accomplishments

Chlamydia is one of the most common, treatable, sexually transmitted infections affecting women of reproductive age in the United States today. Chlamydia causes complications related to fertility and pregnancy, including increased rates of premature delivery, premature rupture of membranes and low birth weight. Tennessee, through family planning clinics and the sexually transmitted disease (STD) clinics, is providing screening and treatment statewide. The state is also participating in the Region IV Infertility Project funded through the Centers for Disease Control and Prevention. Approximately 100,000 tests are conducted annually. Both state appropriations and federal infertility project funds are available for the program.

In January 2003, the State Laboratory switched to the Aptima Combo 2 (by Gen-Probe). Both swab and urine tests are available. Protocols were developed and distributed to the clinics. The use of the amplified test during 2003 has greatly increased the number of positive results for chlamydia in all geographic areas, both rural and metropolitan. The availability of the urine tests has also allowed for more off-site testing for chlamydia and gonorrhea. Data for calendar year 2003 show a positivity rate of 11.1 percent as compared to 6.6 percent for 2002.

Data by program show that fifty percent of the tests were for family planning clients, with a positivity rate of 5.2 percent. This compares to a positivity rate of 18.5 percent in the STD clinic clients. Overall project data by age show a rate of 9.4 percent in clients under age 15, 14.1 percent in ages 15-19, 13.7 percent in ages 20-24, and 10.2 percent in ages 25-29. Rates by sex show 7.9 percent in females (76 percent of total tests) and 21.1 percent in males.

During 2003 the system for capturing the screening data was changed from entries at the Laboratory to the use of a Lab Order Entry Module in the PTBMIS system in local health departments. Entering the data at the clinic level is reducing data errors, but changing systems created the usual problems related to training and implementation.

#### b. Current Activities

Chlamydia screening is continuing in all family planning and sexually transmitted diseases clinics statewide. Risk assessments and screening are also provided to adolescents being provided EPSDT screening exams in the local health department clinics, using the new urine tests. Staff continue to work with TennCare to monitor implementation of chlamydia screening

as a quality of care monitoring indicator. Staff continue to participate on the Region VI infertility project advisory committee.

In January 2004, the Department approved the use of directly observed therapy (DOT) by non-medical personnel (public health representatives/disease intervention specialists) using azithromycin for the treatment of chlamydia. This new policy is not designed to substitute for clinic visits but provides an option for dealing with the most difficult patients and contacts.

In April the program participated in the Region IV Chlamydia Awareness Month by offering chlamydia and gonorrhea urine screening to all women presenting to the local health department clinics for a pregnancy test (excluding those who had been routinely screened in family planning). Preliminary data show that this is a potential target population needing to be offered routine screening. Screening was also offered during April at 12 colleges and universities and 6 other sites such as juvenile detention, group homes, etc.

During 2002, staff worked with the Board of Medical Examiners and the Board of Osteopaths on the adoption of an amendment to the Medical Practice Act allowing physicians and nurse practitioners to provide patients with a prescription or medication for the treatment of chlamydia in their named or unnamed sexual contacts. Local health department clinic staff were provided public health nurse protocols to implement partner delivered therapy within their clinics. The Knox County Health Department has implemented these protocols in their operations.

Other current year activities include analyzing the project data from health department clinics by geographic area, by clinic type, and by age groups; analyzing statewide chlamydia morbidity data; analyzing data from the April special screening activities; and including information on chlamydia in the Nashville All About Women show to be held in August (the Department will have an exhibit; 20,000 women are expected to attend).

### c. Plan for the Coming Year

Plans include continuing all the activities described in current activities, using urine-based testing in select youth detention facilities; using urine-based testing in appropriately targeted outreach screening initiatives; pursuing directly observed therapy by non-medical staff for treating chlamydia; and working with the Board of Regents to include chlamydia screening in student health centers in colleges and universities.

Plans also include identifying new partners in the state for expanding screening efforts; these include ACOG, Tennessee Primary Care Association, and Job Corps.

The Department will also begin planning for Chlamydia Awareness Month for 2005.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) After implementation of folic acid education at the state, regional, and local levels, reduce the number of neural tube defects births.				
1. Expand the CME offering in CD format to dietitians, nurses, and other health care providers; place the material on the Department's web site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Coordinate the Tennessee Folic Acid Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Staff major exhibit at 2-day All About Women Show.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continue distribution of printed materials, presentations, exhibits, and media events statewide.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Maintain folic acid curriculum on Department's web site; update as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Distribute multivitamins to non-pregnant reproductive age women in all local health department clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Provide training for Girl Scout leaders and educational materials for Girl Scouts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Reduce to no more than 4% elevated blood lead levels in children 6-72 months of age who are screened.				
1. Collect, manage, and analyze screening data.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Work with TennCare providers on blood lead screening requirements.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Screen in local health department clinics, including screening in EPSDT.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide case management for children with elevated blood lead levels.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Continue education of providers and citizens.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Develop a protocol for screening pregnant women.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).				
1. Implement community and school-based activities through 42 youth groups across the state.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participate on the advisory board of the Department of Agriculture's SYNAR project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with the Department of Agriculture on education of retailers and the community on the importance of non-sale of tobacco products to minors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Host the annual Youth Tobacco Summit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in the Great American Smoke Out and Kick Butts Day national initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Coordinate the Youth Day on the Hill (advocacy training for youth and visits with state legislators).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Health Educators continue to partner with schools and community groups on prevention efforts.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Reduce the percentage of high school students using alcohol.				
1. Community Prevention Initiative will continue to fund 70 community-based programs in 51 counties that target high risk behaviors in youth.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Bureau of Alcohol and Drug Abuse Services will continue to fund three prevention projects; develop and support coalitions across the state; and sponsor three Teen Institutes to train teams of adults and adolescents in prevention strategies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.				
1. Provide home visiting services statewide to pregnant women and families of infants and young children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide technical assistance, training, and resources to child care providers through the network of Child Care Resource and Referral Centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Make referrals for families accessing any type of health department programs and needing additional services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Develop the long term plan for the Early Childhood Comprehensive Systems Planning Grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Reduce the number of HIV infected infants to no more than one per year.				
1. Offer HIV counseling and testing services for pregnant women in all local health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Offer pregnancy testing, HIV testing services for women with positive tests, and referrals in all local health departments.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assess risk behaviors and need for services of all family planning clients seen in local health department clinics.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.				
1. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT screening.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide EPSDT screening exams to TennCare enrollees in all local health department clinics.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assist families with referrals to and appointments for screenings with the primary care providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide EPSDT screening exams for all children in custody of the Department of Children's Services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Implement the EPSDT community outreach project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family				

planning clinics.				
1. Screen for chlamydia in family planning and sexually transmitted disease clinics in local health departments.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide risk assessments and screening for adolescents as part of the EPSDT screening.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to coordinate with TennCare on chlamydia screening as a quality of care monitoring indicator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate on the Region IV Infertility Project Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Encourage use of directly observed therapy by non-medical personnel.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Encourage us of partner delivered therapy.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Participate in the Region IV Chlamydia Awareness Month.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

The MCH section operates three hotlines. Two are staffed by the MCH section, and one is established with a community-based agency. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing and prenatal care within the area where they live, and respond to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. Patient information is provided to TennCare high risk pregnant women enrolled in Blue Care, a TennCare MCO. Over 40 health education materials are available for distribution.

The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services.

Call GWEN is a statewide teen hotline contracted to United Neighborhood Health Services, which operates primary care centers in Nashville. The agency runs programs that provide counseling services for pregnant and parenting teens. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.

MCH has three advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; and the Children's Special Services Advisory Committee.

Quality Management System: The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Director of MCH serves on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys are conducted for one week of every year in all rural clinics.

Additional information related to II. E. State Agency Coordination:

Adolescent Health Program -- During this past year the adolescent health director created an Adolescent Health Leadership team comprised of all Department staff who work with adolescents and young adults ages 10-24. Representatives from the Commissioner's office, Alcohol and Drug Bureau, Community Services, HIV/AIDS, Office of Minority Health, WIC, and MCH attend the quarterly meetings.

In February 2004, the Association of Maternal and Child Health Programs (AMCHP) and the State Adolescent Health Coordinators Network (SAHCN) selected Tennessee as one of three states to participate in an adolescent health systems capacity assessment tool pilot project. In May 2003, three consultants from AMCHP and SAHCN led a team of 14 people from within the Department of Health through a two day session where the tool was applied to assess Tennessee's systems capacity level to address adolescent health issues. Participants included staff from MCH, Community Services, the Commissioner's office and Planning and Evaluation office. Feedback from the two day process was collected so that the tool could be refined to better meet the needs of state adolescent health personnel throughout the U.S. A final systems capacity assessment report will be provided to Tennessee staff by fall 2004.

Youth health guides were purchased for Tennessee and are in the process of being distributed in partnership with the Departments of Education, Mental Health and Developmental Disabilities, Children's Services, and Human Services. Adolescent health surveys have been developed and are in the process of being distributed in partnership with both public and private providers of adolescent health care. One public health nurse from each of the 13 regions throughout the state were identified as new contact persons with special interest and expertise in adolescent health care. These nurses attended a special adolescent health care training in Boston as the first step towards establishing new regional partnerships to address adolescent health. The first meeting of this group will be held in August 2004 to follow up on material presented at the conference and to plan new adolescent health training initiatives for staff in their regions.

## **F. TECHNICAL ASSISTANCE**

Tennessee is requesting technical assistance in two areas.

Adolescent Health:

Strategic Planning -- For the past year, the Director of Adolescent Health has been laying the foundation to develop a state strategic plan to address adolescent health issues. Currently, a first ever adolescent health data report is being written, 30 youth focus groups are being conducted throughout the state, and adolescent health surveys have been distributed to public and private providers of adolescent health care. Once these data have been collected and analyzed it will be time to bring together a diverse group of people from throughout the state to create a comprehensive adolescent health strategic plan. Technical assistance is requested to assist in all phases of developing this strategic plan.

Data -- Technical assistance is requested to guide the identification, analysis and reporting of the most recent and compelling adolescent health data as well as access to best program practices. For the past several years, the director of adolescent health has attended the State Adolescent Health Coordinators Network (SAHCN) annual training conference. This conference has provided expert training in a variety of adolescent health topics which has enhanced the capacity to address adolescent health issues in Tennessee.

Children's Special Services (CSHCN):

Transitioning (National Performance Measure #6) -- Technical assistance is requested in developing a statewide system, including implementation and evaluation plans for transitioning CSS children to adulthood. Over the past year the CSS Director has initiated the process for identifying community

resources available for transitioning to adulthood as well as recognizing those services which are not available. The program Plan of Care has been expanded which addresses the needs of the child for transitioning to all phases of adulthood including, health, training, therapy, employment, transportation, independency, and any other transitional needs. By beginning a dialogue with transitional stakeholders, including the family, and other interested agencies, a system of local services and resources will be identified, as well as addressing those needed services that are not available. Those children receiving transitional services will be identified and the process of the transitions to adulthood will be monitored. The program will collaborate and coordinate those identified transitional services received by the child and families and evaluate the effectiveness of those services. It will be expected that the program will be able to evaluate the effectiveness of the existing services and identify those community services that still remain unavailable. By identifying the unavailable services, hopefully funding will address those gaps and ensure that every child in the state is afforded the best possible opportunity for smooth and rewarding transitions to all phases of adulthood.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

The MCH budget for the coming year remains basically the same as previous year submittals. The unobligated funds are reflected on Form 2. The required federal percentages for preventive and primary care for children (30%), children with special health care needs (30%) and administrative costs for Title V (10%) are met or exceeded. Other sources of MCH funding include the required state match and other federal grants in support of MCH activity (Title X, CISS, Childhood Lead Poisoning Prevention Grant, SSDI, Abstinence Education, Newborn Hearing Screening, Early Comprehensive Childhood Systems, and Child Health and Development Program).

Because of the unique rules established allowing states to spend Title V funds over 24 months even though they are allocated annually, Tennessee uses this revenue source as the last dollar spent to support services for women, infants and children. Funds are used to support central office, local health departments, including metropolitan health departments, and services offered through special agency contracts. The contracts are used to fill gaps in service or to provide unique services to specific populations. Examples of MCH contracts are genetics and newborn screening services, services for CSHCN, abstinence education, home visitation programs, and family planning.

Detailed budget documentation is maintained in the fiscal office for the Bureau of Health Services and available for review as needed.

The only significant variation in expenditures from the previous year is on Form 4. The methodology used to divide expenditures for FY 2002 on Form 4 by the requested categories was revised. The revised method was determined to be a more accurate representation of the expenditures for the various categories, and uses recent service data for the determination. The same methodology was used to prepare the projected budget for FY 2004.

The financial control of all Department of Health programs is the responsibility of the Bureau of Administrative Services, which has a computerized system for availability of funds, program expenditures, and revenues collected.

Detailed Bureau of Health Services policies and procedures have been established for local health departments, regional offices, and the central office for all staff who are involved in management of funds and the process of contracting for services. These policies and procedures are available at all sites and are posted on the Bureau of Health Services' Intranet for easy reference by staff in all rural health departments and rural regional offices. These include procedures on who handles money, collecting fees, depositing fees, accounts receivables, aging of accounts, charging patients, private insurance and other third party funding sources, petty cash, posting receipts, etc. All policies and procedures have been developed in accordance with state law and procedures of the Department of Finance and Administration.

Computer printouts are generated for all MCH programs on expenditures and revenues, comparison to budgeted amounts and year-to-date activity. These are available on-line to the central office staff and regional office staff in the rural regions for tracking and monitoring expenditures and revenues by type. Financial audits are the overall responsibility of the Office of the Comptroller of the Treasury, which is responsible for audits in all state departments and all matters related to audits. Contracting agencies are subject to audit on a regular basis.

Metropolitan health departments operate within metro governments and have similar policies in place.

### **B. BUDGET**

State law requires that all departments present a complete financial plan for the ensuing fiscal year that outlines all proposed expenditures for the administration, operation and maintenance of all programs. Procedures for completing the budget request are developed annually by the Department

of Finance and Administration. The Bureau's Fiscal Services Section, with input from the program areas, is responsible for completion of the budget documents. After being approved by the State Legislature, an operational budget work plan is developed for each program for the year.

Under the system of resource allocation (described below) for both rural and metropolitan health departments, MCH dollars are used to budget for ongoing services and to fill gaps in annual fluctuations and unanticipated needs. The result is variation in amount of Title V carryover from year to year. An example of variation of carryover is the receipt of specialized grants by MCH and other sections that reduce the amount needed from the MCH Block Grant to support services during the time period of the grant. Other variations occur due to the large number of positions funded with MCH dollars at all levels of the public health system and the potential for wide variations in the number of vacancies during the year, recruiting efforts, and problems filling positions timely.

The Department of Health uses a cost allocation system for local health departments. Costs are allocated to programs in the rural health departments using two specific methods of charging costs: (1) Direct Cost Allocation method and (2) Resource Based Relative Value Scale Method (RBRVS). The direct cost allocation method is used when cost categories can be directly allocated to one or more programs. Salaries and benefits can be directly allocated via coding into the Labor Distribution System. Other costs such as travel, supplies, printing, contracts and equipment can be directly charged to programs via various accounting documents used by the state. This direct cost allocation method is reserved for costs that arise from administrative support staff in the Bureau of Health Services' central and regional offices and for contractual costs with metropolitan governments. The RBRVS method is the principal method of cost allocation used to spread to all programs in local health departments those costs which cannot be directly allocated to one or more programs. RBRVS adds up all weighted encounter activities using Relative Value Units (RVU) and allocates costs based on percent of activity for each program cost center. The Department of Health and Human Services, our cognizant agency, has approved RBRVS as an activity based cost allocation method for the Tennessee Department of Health. RBRVS is fully automated with computer linkages at the service delivery level to AS400 computers at the regional and central offices. Program encounter data are entered for local health department services using CPT procedure codes and program codes. Relative Value Units assigned to each procedure code allows a proportionate amount of cost to be associated with each procedure. Metropolitan health departments also use the PTBMIS data system to document services provided by staff. The State uses a multi-service contract to specify services that are provided by metropolitan health departments for MCH and other services. In state fiscal year 2002-3, approximately 3.6 million dollars were available from MCH Block Grant to support services for women and children in metropolitan areas.

The state established a Maintenance of Effort (MOE) state appropriation baseline in 1989 in accordance with the requirements of the Block Grant. The Fiscal Services Section of the Bureau of Health Services developed a formula for establishing the MOE based on state expenditure data for the 15-month period from July 1, 1988, through September 30, 1989, to bring expenditures current to the end of federal FY 1989. Then, state expenditures for July 1, 1988, through September 30, 1989, were totaled and subtracted from the 15-month expenditure amount, resulting in a 12-month total for the Federal FY of October 1, 1988 - September 30, 1989.

Accrued liabilities for the state fiscal year ending June 30, 1989, were determined and subtracted from the 12-month Federal FY total. Accrued liabilities are those costs that could not be liquidated at the close of the fiscal year but represent a liability to the state for the fiscal year in which they occurred. Accrued liabilities for October 1, 1988/June 30, 1989 and July 1, 1988/September 30, 1989 were determined. Since these accrued liability liquidations are actual expenditures in the fiscal year, they were added to the funding total. Unliquidated accrued liability savings were determined from the 1988 established accrued liabilities and adjusted as expenditures. These computations resulted in the establishment of the MOE of \$13,125,024.28 in state funds for MCH.

MCH and other Department of Health programs achieve matching state dollar requirements through the state appropriation to the Department, earned income from services and in-kind match for special

contracts for services to women and children. One strategy MCH implemented is aggressive reimbursement from MCOs for prior authorized services, especially for CSHCN. These are tracked through regional and central office fiscal management.

For the last few years, the unobligated balance carried forward by MCH has been significant. Reasons for this variation have been explained in the previous paragraphs. The carryover funds allow us to develop new services or initiate services that could be revenue producing in the future. During the past two years several major activities have been addressed using the MCH carryover funds. MCH partnered with several other departmental programs to expand and improve dental services and other health screening services with an emphasis on children. Three mobile dental vans were purchased for use in rural, underserved areas. The mobile clinics provide follow up services for those children screened through school-based dental program. While these services are targeted at TennCare enrolled children; others with private insurance but no dental coverage and children without any insurance also receive services. MCH carryover dollars were used to expand the use of universal newborn hearing screening in birthing hospitals that did not currently have equipment and/or did not routinely screen all babies born in their facilities. Home visiting services for pregnant women and families with high risk infants and young children were expanded, as was care coordination services for families with children with special health care needs.

For the first two years of the current Administration, the Governor spent considerable time developing a budget for State Government which was within available resources. The budget for maternal and child health services for FY 2004-2005 remains basically the same as previous years. Unobligated funds are reflected on Form 2. The required federal percentages for preventive and primary care services for children (30%), children with special health care needs (30%), and administrative costs (10%) are met. Other sources of MCH funding include the required state match and other federal grants in support of MCH activity and under the direction of the MCH director. These include grants for lead poisoning prevention, family planning, health consultants in child care centers, abstinence, SSDI, and newborn hearing screening. Services, activities, and programs funded with the MCH Block Grant dollars are described within this document and represent all components of the MCH pyramid and include all target populations. Expanding MCH services for FY 2005 include implementation of new EPSDT outreach plans under contract with TennCare and implementation of the Early Comprehensive Childhood Systems grant.

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.